A Report
to the
Montana
Legislature

Performance Audit

State Employee Health Clinics Contract Management and Oversight

Department of Administration

June 2017

Legislative Audit
Division

16P-03

Legislative Audit Committee

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Performance Audits

Performance audits conducted by the Legislative Audit Division are designed to assess state government operations. From the audit work, a determination is made as to whether agencies and programs are accomplishing their purposes, and whether they can do so with greater efficiency and economy.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Members of the performance audit staff hold degrees in disciplines appropriate to the audit process.

Performance audits are conducted at the request of the Legislative Audit Committee which is a bicameral and bipartisan standing committee of the Montana Legislature. The committee consists of six members of the Senate and six members of the House of Representatives.

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June 2017

The Legislative Audit Committee
of the Montana State Legislature:

This is our performance audit of the Montana Health Centers (MHC), also known as the employee health clinics, which are administered by the Department of Administration. This report includes recommendations to improve administration of the MHCs. Recommendations include developing an organizational vision for the MHC program, along with clear, measurable goals and objectives; obtaining more complete patient data from the MHC contractor; developing a growth plan for future expansion; improving communications between the MHCs and private health care providers; and issuing a new Request for Proposal for the centers. A written response from the Department of Administration is included at the end of the report.

We wish to express our appreciation to department staff and the MHC contractor personnel for their cooperation and assistance throughout the audit.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

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Performance Audit
State Employee Health Clinics Contract Management and Oversight
Department of Administration

June 2017 16P-03 Report Summary

Since 2012, the Department of Administration has expended approximately $26.1 million to operate the Montana Health Centers, also known as the employee health clinics. There have been ongoing management challenges with operating the health centers beginning with a poorly drafted Request for Proposal, contract management weaknesses, and a lack of reliable data to assess contractor performance. Consequently, any reports of health care cost savings to the state of Montana cannot be corroborated. If this health care benefit is to continue, DOA needs to work with stakeholders, including legislators, state employees, the Montana University System, and private health care providers, to develop a long-term strategy for MHC operations and services. This would include developing a new Request for Proposal with a clearly defined vision and goals for MHC operations.

Context

In an effort to control health care costs over the long term, many employers are focusing on improving the overall health of their workforce. One method to help achieve this goal is through the creation of on-site employee health clinics. The Montana Health Centers (MHC) specialize in primary care and health and wellness coaching, diagnostic service referrals, health screenings, and vaccinations to state employees and qualifying dependents covered under the State of Montana Benefit Plan. The Department of Administration's (DOA) Health Care and Benefits Division (HCBD) oversees the MHCs via a contract between the division and a contracted third-party vendor (contractor). The contractor is in its fifth year as the day-to-day operator of the MHCs, and is currently under a one-year contract extension. These contracts between HCBD and the contractor contain performance guarantees meant to improve performance and ensure the contractor performs all of its contractual obligations.

The first MHC opened in Helena in August 2012, with five additional centers opening in the following three years. There are no patient fees, such as co-pays or deductibles, associated with services received at the MHCs. However, between August 2012 and August 2016, operating costs for the MHCs have totaled more than $26.1 million.

Through survey work, we found the MHCs are being used by employees primarily for annual health risk assessments and primary care, with nearly a third of respondents also using the centers' wellness coaching services. Seventy-three percent of respondents use the MHCs up to five times a year with an additional 17 percent visiting up to nine times annually. Overall, survey respondents stated they are satisfied with the quality of care they received at the MHCs.

Results

Audit work found ongoing contract management weaknesses related to the MHC contract. Specific issues identified included a lack of accurate and complete electronic medical records data to track long-term health

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of patients; immeasurable and vague goals and performance guarantees; inaccurate contractor reporting and unfounded savings attributed to the centers; and disruption of care between the centers and private health care providers. Audit recommendations to DOA include:

- Defining types of visits available at the MHCs.
- Regularly conduct independent audits of the MHCs.
- Creating a growth plan for potential future expansion of the MHCs.
- Improving communication between the MHCs and private health care providers.
- Educating employees on what an electronic medical record is and how to distribute their records between the MHCs and their private health care providers.
- Linking performance incentives to the goals of the MHCs using clearly defined, measurable outcomes.
- Collecting accurate and comprehensive patient data and completing the data warehouse.
- Requiring future contract modifications to be in written format.
- Developing a vision for the MHCs, including clear and measurable goals.
- Developing a new Request for Proposal to align with the newly created vision, goals, and objectives.

Recommendation Concurrence	
Concur	8
Partially Concur	1
Do Not Concur	0

Source: Agency audit response included in final report.

For a complete copy of the report (16P-03) or for further information, contact the Legislative Audit Division at 406-444-3122; e-mail to **lad@mt.gov**; or check the web site at **http://leg.mt.gov/audit**
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Chapter I – Introduction and Background

Introduction

In an effort to control health care costs over the long term, many employers are focusing on improving the overall health of their workforce. One such method to achieve this goal is through the creation of on-site employee health clinics. A 2015 national survey found 29 percent of employers with 5,000 or more employees provided an on-site or near-site center offering primary care services. This was an increase from 24 percent of employers the prior year. In 2012, the state of Montana contracted with a private vendor to operate employee health clinics, officially known as the Montana Health Centers (MHC). The first MHC opened in Helena in August 2012. Since that time, five additional MHCs have opened across the state. MHCs are available to state employees and their dependents who are covered under the State of Montana Benefit Plan (State Plan). The State Plan includes medical, vision, dental, and prescription plans available to state employees and their dependents.

The Health Care and Benefits Division (HCBD), under the Department of Administration (DOA), is responsible for overseeing the MHC contract. The MHCs specialize in primary care, health and wellness coaching, diagnostic service referrals, health screenings, and vaccinations for state employees and qualifying dependents. The MHCs are funded through the State Plan. Between August 2012 and August 2016, operating costs for the MHCs have totaled more than $26.1 million. There has been ongoing legislative interest in MHC operations, the services they provide, the costs associated for operations, and any health cost savings the state has realized since the MHCs have opened. As a result, the Legislative Audit Committee prioritized a performance audit of the MHCs. This chapter discusses the scope, objectives, and methodologies of our audit, as well as background information about the MHCs, the services they provide, and HCBD's role in managing the contract.

Audit Objectives

During audit assessment work, we reviewed all contracts and amendments relating to the MHCs, the purpose of the centers, interest from stakeholders, and costs associated with operating the centers. The potential risk areas centered on operation costs, potential impacts to local health care providers, and the management of the MHC contract. This led to the development of the following audit objectives:

1. Determine if the Montana Health Centers are providing health care services at a lower cost when compared to similar service providers.
2. Determine what, if any, impacts the implementation of the Montana Health Centers has had on local health care providers in communities where the Montana Heath Centers are located.

3. Evaluate the Department of Administration's process for monitoring the on-site health care contract to determine how Montana Health Center usage and costs are validated.

Audit Scope

Audit assessment work and interviews with DOA, the Montana University System, and other stakeholders led us to focus audit work on a number of areas, such as: cost comparisons between the MHCs and local health care providers; contract management; the MHC contractor's electronic medical records (EMR); impacts on local health care providers; and contract performance guarantees.

In order for a health care provider to be paid for its services, a medical billing insurance claim is created, which explains how a provider treated a patient. This claim is then sent to a designated payer. The payer then reviews the claim and determines which services it will reimburse. Because of the high number of members on the State Plan (approximately 33,000), HCBD contracts with third-party administrators (TPA) to process health care-related claims. Audit work consisted of examining all MHC patient EMR data from August 2012 through December 2015, and all TPA claims data for calendar years 2013 through 2015, the last complete year available during fieldwork. All claims and EMR data was received from HCBD's contract actuary and was de-identified to protect the privacy of individual patients. The comparison between MHC visits and local health care provider visits included those health care services that are provided at MHCs. This comparison was done to determine if there are cost savings attributable to the MHCs when compared to private health care providers. In the health care industry, there are two records used for viewing patient visit information: an EMR and an electronic health record (EHR). An EMR is a digital version of the paper charts found in a clinician office, clinic, or hospital that contains notes and information collected by and for clinicians in that office, clinic, or hospital. EMRs are primarily used by providers for diagnosis and treatment purposes. An EHR contains information from all clinicians involved in a patient's care, and all authorized clinicians involved in a patient's care can access the information to provide care to that patient. EHRs also share information with other health care providers, such as laboratories and specialists. In this report we will refer only to EMRs, though there may be instances where an EHR is more appropriate.

Audit work also included surveying Executive and Judicial Branch state employees to help assess how employees use MHCs and the quality of health care services provided to them and their dependents. The survey also helped audit staff evaluate accessibility to MHCs, the types of services patients use at the MHCs, and overall satisfaction with the quality of care they receive. A survey was also sent to hospitals in areas with an MHC to determine if the centers have had an impact on their operations, such

as lower patient numbers or loss of revenue. Cost comparisons between the MHCs and similar services done through local health care providers consisted of looking at potential costs savings to the state.

Contract management was also a focus during fieldwork–specifically, what HCBD is doing to monitor the contract associated with operating the MHCs. This included reviewing the Request for Proposal (RFP), the original contract, all associated amendments, and contract performance guarantees; analyzing patient claims and EMR data to track patient services; and reviewing contractor invoices.

Audit Methodologies

The following methodologies were performed to answer our objectives:

- Reviewed state laws and administrative rules related to health care and benefits.
- Reviewed minutes from the Legislative Finance Committee and the State Employee Group Benefits Advisory Council (SEGBAC), and reports from the Legislative Fiscal Division (LFD) to learn the extent to which MHC operations are reported.
- Reviewed the MHC Request for Proposal, the contractor's RFP response, the initial contract, and subsequent amendments to learn the goals and objectives of the MHCs.
- Reviewed an MHC review by HCBD's third-party actuary, which provided MHC visit numbers, access to health coaches, local provider impacts, and health screening participation.
- Reviewed contractor invoices paid by HCBD to get a better understanding of MHC expenditures.
- Surveyed approximately 12,400 state employees in August 2016 (33 percent response rate) that were part of the State of Montana Benefit Plan to determine the employees' perspectives on the MHCs, and why and how they are using them. This is a sufficient representation of the opinion of state workers.
- Surveyed all 21 hospitals and critical access hospitals within the service areas of the MHCs (76 percent response rate). We also surveyed Montana primary care providers but did not use the results because of limited volume and quality of responses.
- Reviewed numerous contractor-generated MHC documents to determine what is being reported to HCBD and to compare its data to our data analysis findings.
- Reviewed all MHC-related expenses from August 2012 through August 2016 to better understand the costs required to operate the centers.
- Reviewed all third-party administrator health care claims data from January 2012 through December 2015 to determine the state's costs for these services.

- Reviewed all the contractor's MHC patient EMR data from August 2012 through December 2015 to learn why patients are visiting the MHCs.
- Interviewed various HCBD staff, contracted actuary staff, MUS staff, hospital administrative staff, health care providers, and the MHC contractor's staff throughout the course of assessment and fieldwork.
- Interviewed a former HCBD contractor to obtain input regarding how the state used to implement annual health screenings before the MHCs opened.

The Montana Health Centers

State employees and their dependents who are members of the State Plan can use the MHCs for their primary care and wellness service needs.

- Primary care is health service that covers a range of prevention, wellness, and treatment for common illnesses, usually done by doctors, nurses, nurse practitioners, and physician assistants. The intent is to maintain long-term relationships with patients and to advise and treat them on a range of health-related issues. Primary care providers also act as gatekeepers to manage downstream procedures and costs. Primary care services provided at the MHCs include treatment of chronic and acute conditions, as well as other services such as comprehensive wellness physicals.
- Wellness services at the MHCs focus on programs intended to improve and promote health and fitness. A wellness visit is usually based on results of a blood test done as part of a patient's annual health risk assessment (HRA). The MHCs use the results of HRAs to identify potential health risk factors and manage chronic conditions. Health care providers and coaches then use these results to guide patients to healthier lifestyles.

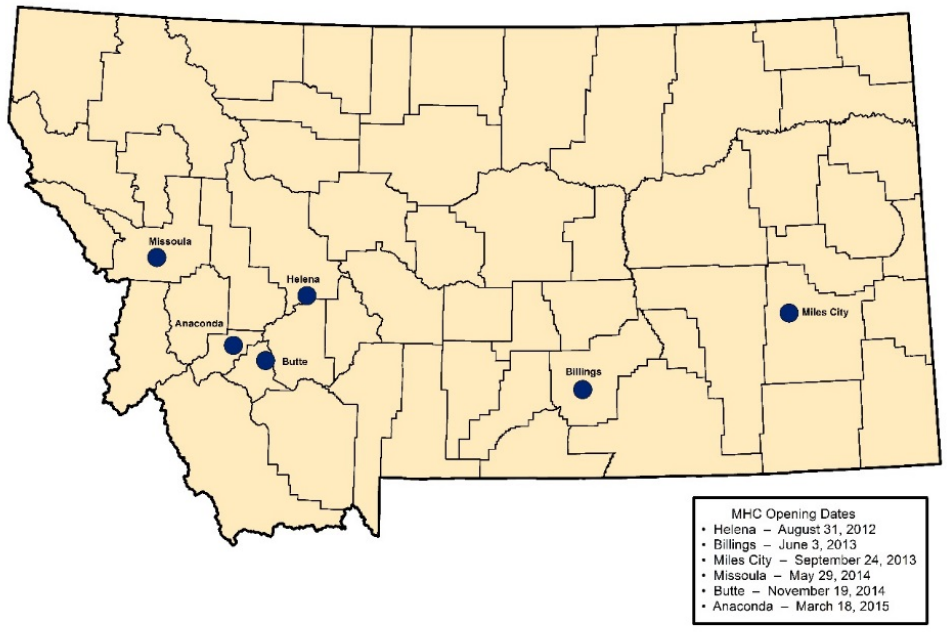
In early 2012, state officials proposed the idea of opening MHCs as a way of improving access to primary care and to save costs to the State Plan, which is self-insured. Self-insured plans are funded by employer and employee contributions held in a reserve. Rather than purchasing a health insurance policy from private insurance companies, the employer assumes the financial risk for providing health care benefits for its employees and their dependents. The employer then pays medical claims for its employees and eligible dependents in accordance with the benefits outlined in a summary plan document. This means the money that pays for health care expenses comes from two sources: 1) the state's share, which is $1,054 per month per employee in 2017 and is set by the legislature, and 2) plan members' monthly contributions, which are based on their dependents on the State Plan and which optional benefits are chosen. Under §2-18-808, MCA, DOA has the authority to provide state employees with adequate group hospitalization, health, medical, and other related group benefits in an efficient manner and at an affordable cost. Specifically, under §2-18-812, MCA, DOA may establish alternatives to conventional insurance for providing state employee group benefits. With this authority, DOA issued an RFP for the MHCs in

February 2012, with responses due that April. In May 2012, an on-site health center operator (contractor) headquartered in Tennessee was chosen as the vendor to operate the MHCs, with the first center opening in Helena that August. Within the RFP, there are "primary" goals, which include the following:

- Increase access to primary care services,
- Improve health outcomes for members,
- Improve treatment and compliance for patients with chronic health conditions,
- Provide access to health coaching and care management,
- Reduce costs for the state health plan and plan members,
- Provide health screening services,
- Reduce reliance on emergency room and urgent care,
- Improve employee productivity and reduce absenteeism, and
- Develop occupational health capacity and reduce workers' compensation costs.

There are no patient fees, such as co-pays or deductibles, associated with services received at the MHCs. A co-pay is a fixed amount the patient pays for a covered health care service, usually at the time of service. A deductible is the amount a patient owes for covered health care services before their health insurance plan begins to pay. There are also no fees associated with X-rays and ultrasounds prescribed by an MHC provider, which are provided by local imaging providers, where available. The MHCs are available to active state employees and non-Medicare retirees covered by the State Plan, and dependents and non-Medicare dependents covered by the State Plan that are age two or older. According to HCBD staff, the intention was for state employees to use the MHCs as their primary care provider. There are currently six MHCs located throughout Montana, which are found in Figure 1 (see page 6).

Figure 1
MHC Locations



Source: Compiled by the Legislative Audit Division using GIS software and SABHRS records.

The Montana Health Center Contract

The original contract between the contractor and DOA was from June 1, 2012, through December 31, 2015, with one-year extensions signed for 2016 and 2017. Under the contract, the contractor is expected to work closely with HCBD to design, operate, and effectively manage the MHCs for the state. The contract also allowed the contractor to invite other public entities to participate in the contract as long as they abide by the contract terms. There are currently participation agreements in place with the following entities:

- **Montana University System:** Staff at the Office of Commissioner of Higher Education and the Helena College of Technology participate in the MHC contract.
- **Montana Municipal Interlocal Authority (MMIA):** MMIA includes employees of city and county government around the state of Montana. Participants in the contract currently include Helena, East Helena, and Miles City.
- **Montana Unified School Trust (MUST):** Qualifying teachers, administrators, and support staff from school districts that are part of MUST may use the MHCs.
- **Butte-Silver Bow Consolidated City Government**

These four entities pay the contractor directly for all subcontracted services (lab and imaging costs, etc.) and a prorated amount for all salary and supply costs based on their visitation percentages. They also pay the contractor the same management fee that HCBD pays. Finally, these entities pay HCBD $3.80 per visit to cover overhead costs of lease, utilities, and equipment.

State Employees Health Clinics Opening in Other States

In recent years, several state governments have instituted on-site employee health clinics in an effort to contain rising health care costs and provide convenient health care to employees. Since 2010, employee health clinics have opened in Alabama, Kentucky, Tennessee, New Mexico, and Missouri. In 2015, Utah passed legislation to initiate a pilot program creating a state employee clinic. Most clinics offer some form of acute/urgent care, wellness screenings, and vaccinations. Some, such as Alabama, include an on-site pharmacy. States are split on whether they market their clinics as providers of primary care: New Mexico, Kentucky, and Utah consider their health clinics to be primary care providers, while Alabama, Tennessee, and Missouri do not. Likewise, states are split on whether their clinics treat the dependents of employees. For example, Alabama and New Mexico treat dependents, while Kentucky, Tennessee, and Missouri do not. With the exception of Alabama, which contracted with a state university, all the states we contacted contract their clinic services with a private contractor. In addition, these clinics operate only in their state capitals; in some cases, states intend to expand only after determining if the existing clinics are achieving goals and operating efficiently. Based on our interviews with these other states, we found Montana has the most expansive health clinics in terms of types of services provided and the number of locations and staff reached.

Report Contents

The remainder of this report contains information regarding our audit findings, conclusions, and recommendations.

- Chapter II discusses the cost effectiveness of the Montana Health Centers' business model.
- Chapter III discusses the impacts of the Montana Health Centers on local health care providers.
- Chapter IV details the weaknesses of the Montana Health Centers contract.

Chapter II – Cost Effectiveness of the Montana Health Centers' Business Model

Introduction

When the first Montana Health Center (MHC) was opened in August 2012, there were questions from legislators, employees, and other stakeholders regarding whether or not these centers would provide services at a lower cost than similar services from private health care providers. In this chapter, we discuss our analysis of the cost-per-visit at each MHC and compare these costs to what the state pays for patient care at private health care providers. Our work included analyzing MHC operating costs, reviewing claims data from local providers and MHC patient electronic medical record data, and reviewing utilization rates at all the centers. (An electronic medical record (EMR) is a digital version of a paper chart that contains all of a patient's medical history from one practice.) Ultimately, audit work found that a cost comparison between the MHCs and local private health care providers could not be accurately conducted because the entities operate under different health care business models. As a result, not all reports of cost savings attributed to the MHCs can be supported. The following sections outline how we came to these conclusions.

Costs Associated With Operating the Montana Heath Centers

There are several costs associated with the operations of the MHCs, which are detailed below.

- **Start-up costs:** The state is responsible for the expense of setting up the MHCs. The MHC operator (contractor) purchases the equipment and supplies necessary to open an MHC and is then reimbursed by the Department of Administration's (DOA) Health Care and Benefits Division (HCBD) with a $0 mark-up, meaning the state does not pay anything beyond the cost incurred by the contractor for supplies and services.
- **Lease payments**: The state currently rents/leases all the properties that house the MHCs, with the exception of the Anaconda MHC.
- **Management fees**: Under the current contract between HCBD and the contractor, the state pays for all MHC operating costs and also pays an additional management fee, which provides the contractor a reasonable opportunity to generate a profit. When the initial contract was signed in 2012, HCBD paid the contractor $18 per-employee-per-month (PEPM) for the first 5,000 employees, and $15 PEPM thereafter for those employees covered under the State of Montana Benefit Plan (State Plan) that live within an MHC service area. A one-year renewal contract decreased these amounts to $15 and $12, respectively, starting in January 2016. The contractor also uses this fee to cover the other MHC-related costs, such as a medical director,

wellness and coaching staff, three management positions in Montana, their EMR, and certain travel expenses.

- **Salaries**: The salaries of all MHC staff, who are employees of the contractor, are paid by the contractor and then reimbursed by HCBD with $0 mark-up. The contractor provides all wellness staff of the MHCs, which is paid through the management fee. This includes dieticians, physiologists, behavioral health coaches, tobacco cessation coaches, exercise coaches, a wellness director, and administrative staff.
- **Other fees**: These costs are for ongoing equipment and supplies needed to operate the MHCs. The contractor initially pays for these supplies and is then reimbursed by HCBD with a $0 mark-up.
- **Lab testing fees**: Up until 2017, the contractor outsourced all lab testing to an out-of-state organization. As of January 2017, a hospital in Montana now processes all MHC lab work. All costs associated with lab testing are reimbursed by HCBD with a $0 mark-up. Because lab fees are generated and paid by the State Plan as a result of member visits to the MHCs, we include them within the overall cost analysis, even though they are provided under a different contractual arrangement. According to HCBD documentation, the contractor's lab testing subcontract with an external lab saved the State Plan approximately $2 million between 2015 and 2016. This is due to the external contracted lab being able to process nearly all the MHCs' lab work cheaper than other local Montana health care providers.
- **Imaging fees:** In addition to subcontracting lab testing, the MHC contractor subcontracts with other Montana entities for ultrasound and X-ray imaging. These services are free to employees and cost the state less than the same services paid for in the private market through the State Plan, according to HCBD documentation.
- **Remote Health Risk Assessment (HRA) costs:** The contract includes a requirement that the contractor send staff to state locales that are remote from MHCs to provide on-site HRAs for state employees and their spousal dependents. (The results of HRAs are used to identify potential health risk factors.) Costs include staff salaries, travel mileage reimbursement, and a charge per HRA that includes lab and other costs.

During audit work we obtained cost data associated with operating the MHCs from August 2012, when the first center opened in Helena, through August 2016. Table 1 (see page 11) outlines all these operating costs.

As shown, as of August 2016 the state has spent $26.1 million to operate the MHCs. This total encompasses all those services provided under the umbrella of the MHC contract between HCBD and the contractor, including third-party contracts between the contractor and other entities for services such as lab testing and imaging. Some of these costs would have likely occurred even in the absence of the MHCs. Since December 2014, this has amounted to approximately $628,000 per month. The largest expense is related to the salaries of MHC employees, followed by the contractor's

management fee. These two expenses comprise more than 63 percent of total MHC operating costs. A management fee is a common means of paying contractors who operate on-site employee health clinics. A review of similar state employee health clinics in other states revealed that, while management fees were calculated in varying ways, they were set up in a similar manner. The state reimburses the contractor for direct costs and pays the contractor an additional management fee for managing the clinic. This business model also typically includes performance guarantees in the contract to reduce or increase the contractor's management fee depending on its achievement of specific goals.

Table 1
Breakdown of Total Expenditures Associated With the Montana Health Centers
August 2012 through August 2016

Expenditure Type	Total Costs	% of Total
Start-Up Costs	$ 305,734	1.2%
Lease Payments	978,462	3.8%
Management Fees	6,497,840	24.9%
Salaries	9,996,030	38.3%
Other	1,756,302	6.7%
Lab Fees	2,125,746	8.1%
Imaging Fees	2,979,131	11.4%
Remote Health Risk Assessments	1,451,702	5.6%
Total	**$26,090,947**	**100%**

Source: Compiled by the Legislative Audit Division from HCBD records.

Montana Health Center Lease Payments Have Cost Nearly One Million Dollars

HCBD spent nearly $1 million since the opening of the MHCs to lease the buildings that house five of the six MHCs: Billings, Butte, Helena, Miles City, and Missoula. Lease payments associated with the MHC in Anaconda are paid through a unique facility charge since it is operated under a contract between the contractor and the local Anaconda hospital.

Montana Health Center Appointment Definitions and Utilization Rates Are Unreliable

To help answer our objective determining if the MHCs are providing health care services at a lower cost when compared to similar service providers, we wanted to calculate the average cost-per-visit per MHC by year. This was to be done primarily through the review of patient EMRs, which gives details on why a patient went to an MHC. However, this became a challenge when audit work found EMR data from the contractor did not contain the physical location of the MHC where patient visits took place. As a result, we had to rely on appointment and vacancy reports created by the contractor, which showed the number of appointments by MHC location. These reports

also list the total number of appointment slots available and slots used by patients to create a vacancy rate. For example, if there were 100 appointment slots available and 90 slots were used by patients, the MHC would have a vacancy rate of 10 percent. However, review of these vacancy reports found they are unreliable. Our analysis of MHC visit totals, based on reviewing all centers' EMR data from August 2012 through December 2015, differed significantly from the totals the contractor stated in its reports. This is because HCBD, the contractor, and HCBD's contracted actuary who compiles data related to the MHCs, use different definitions of the three types of MHC visits: ancillary visits, office visits, and encounters. In addition, based on our interviews with contractor staff, and reviews of contractor documentation, we determined the contractor also has varying definitions related to ancillary visits, and may not have a definition of an encounter. Table 2 defines these three types of visits from the perspectives of the contractor, HCBD, and HCBD's contracted actuary.

Table 2
Definitions of Visit Type at the Montana Health Centers

Visit Type	MHC Contractor	HCBD	Contracted Actuary
Ancillary Visit	According to staff: Blood draws, screenings, all HRAs, nurse-only visits for services like blood pressure checks, flu shots, and other immunizations. According to contractor documentation: Lab appointments outside of standard MHC schedules, off-site vaccination appointments (i.e. Hepatitis B shots), and remote HRA appointments.	Lab appointments outside of standard center schedules, off-site vaccination, and remote HRA appointments.	Does not have knowledge of ancillary visits.
Office Visit	Primary care medical appointments taken from the appointment schedule.	Occurs when a patient talks with a provider or has an ailment viewed by a provider.	Services performed at a doctor's office on a given visit.
Encounter	Did not respond to requests asking for a definition.	Explanation #1: One meeting that might be comprised of multiple visits. Explanation #2: An encounter is when a patient interacts with a health coach and when a patient has a blood draw.	All services received at an MHC for a specific member on a specific date.

Source: Compiled by the Legislative Audit Division from contractor records.

As shown, there are inconsistencies in the definitions of the three visit types, which is important for two reasons: 1) office visits and ancillary appointments are categorized separately in contractor reporting, and 2) HCBD's contracted actuary stated the contractor's EMR data we analyzed included both ancillary and office care visits. The latter indicates that the number of visits per MHC listed in the vacancy reports are unreliable. We conducted an analysis of the number of office and ancillary visits using data from HCBD's contracted actuary, which was a list of all primary care services provided at the MHCs from August 2012 through December 2015. Using this data, we were able to determine a total number of patient visits during this time frame. We used this information as a comparison to the visits reported by the MHC contractor. Our work found significant differences between the number of documented office visits and ancillary visits we could identify and the number of visits reported by the contractor. Specifically, we identified a total of 140,335 visits between August 2012 and December 2015 compared to 211,033 total visits reported by the contractor. The following table compares the contractor's EMR data to total visits listed in their vacancy reports.

Table 3
Unique Office Visits to the Montana Health Centers
August 2012 through December 2015

LAD Analysis* (Office and Ancillary Visits)	Contractor's Vacancy and Appointment Reports		
	Office Visits	Ancillary Visits	Total Office and Ancillary Visits
140,335	138,514	72,519	211,033

Source: Compiled by the Legislative Audit Division from HCBD records.

*The actuary could not confirm if remote HRAs are included in the claims data.

Employees Requested to Book Unnecessary Appointments

In addition to differences in definitions of certain office visits, audit work also found the contractor was having patients sign up for unnecessary appointments. For example, the contractor often requests 40-minute appointments (back-to-back 20-minute appointments) for first-time patients and as a follow-up appointment to discuss HRAs for some employees. Interviews with contractor staff revealed these requests are random and often not necessary. According to our employee survey, 44 percent of surveyed employees that reported being contacted after their HRA was completed were asked to schedule a 40-minute appointment. However, only about half of those respondents stated their appointment lasted over 20 minutes. A review of the contractor's EMR

data found there was not a section indicating the length of the appointment. This would document that a 40-minute appointment was actually one appointment. When asked what occurs for the second 20-minute slot if the 40-minute appointment takes 20 minutes or less, MHC clinical employee interviews found it gives them the opportunity to catch up on paperwork, and that opening up the second 20-minute appointment for another patient does not occur a "majority" of the time. This could lead to a high number of 20-minute appointments being considered "used" when, in fact, they were not. Follow-up interviews with HCBD staff found they were unaware that the contractor was requesting 40-minute appointments until audit staff brought it to their attention.

Overall, this raises concerns about the accuracy of both the EMR data given to HCBD from the contractor and the appointment and vacancy reports the contractor creates for HCBD. The contract contains incentives, which will be discussed in greater depth in the final chapter. One of these incentives has historically been that the contractor will achieve a threshold of utilization at each MHC. Because employees are asked to book appointments that do not ultimately get used, the contractor's reporting on utilization rates is potentially invalid, which may have resulted in the contractor achieving its performance threshold illegitimately. Ultimately, this could have resulted in the state not receiving a refund from the contractor when it was entitled to one. In addition, unused 20-minute appointments could have an impact on appointment availability, preventing an employee or a dependent from receiving needed medical care.

RECOMMENDATION #1

We recommend the Department of Administration:

A. *Require use of standardized definitions for an office visit, ancillary visit, and an encounter within the Montana Health Centers, and*

B. *Require the contractor to provide accurate Montana Health Center appointment and vacancy reporting based on actual appointment times.*

Montana Health Centers' Cost-Per-Visit Analysis

Initial audit work was going to consist of breaking down a cost-per-visit at each MHC using reports and EMR data issued by the contractor. Ideally, this would include separating visits by type (i.e. HRA, primary care, and wellness coaching) and by MHC location. However, limitations in two areas complicated this analysis: the contractor's EMR data did not include the physical MHC location of each visit, and there is not a clear distinction between the various types of appointments. As a result, we altered

our methodology to calculate the MHC cost-per-visit. This approach used the total visits found in the contractor's EMR data, the percentage of visits per MHC found in the contractor's appointment and vacancy reports, and the total costs to operate the MHCs. This approach allowed us to complete an analysis of the cost-per-visit by MHC.

Our analysis encompasses all patient visits for employees, spouses, dependents, and retirees from August 2012 through December 2015 (the last month available during that phase of audit work). The following table illustrates the total costs since each MHC opened, total patient visits, and the percentage of total statewide patient visits that occurred at each MHC through December 2015.

Table 4
Costs and Visits per Montana Health Center
(August 2012 through December 2015)*

MHC	Date Opened	Total Costs**	Percent of Total Costs	Total Visits***	Percent of Total Visits
Anaconda****	March 18, 2015	$ 128,234	0.8%	1,248	0.9%
Billings	June 3, 2013	1,764,389	11.3%	11,880	8.5%
Butte	November 19, 2014	1,010,340	6.4%	10,474	7.5%
Helena	August 31, 2012	10,743,794	68.6%	103,492	73.7%
Miles City	September 24, 2013	872,428	5.6%	4,196	3.0%
Missoula	May 29, 2014	1,137,091	7.3%	9,045	6.4%
Totals	**N/A**	**$15,656,276**	**100%**	**140,335**	**100%**

Source: Compiled by Legislative Audit Division from HCBD and contractor records.

*Legislative Audit Division had EMR data through December 2015.

**Includes expenditures relating to lease payments, management fees, salaries, and other overhead expenses.

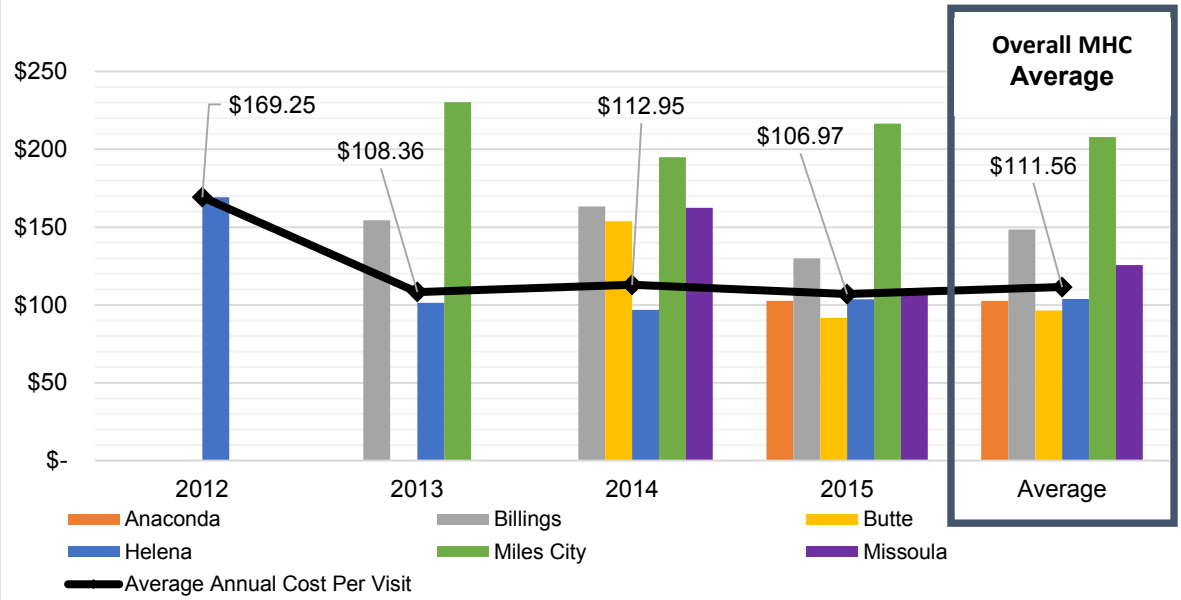
***Based on the percentage of visits per MHC using contractor reports.

****Anaconda is artificially low due to sharing a management fee with the Butte MHC.

As shown in the table, the state spent $15.6 million in MHC lease fees, management fees, salaries, and overhead expenses through December 2015, with 69 percent ($10.7 million) of costs tied to the Helena center (which also saw 74 percent of the total patients). Audit work did not include start-up costs and lab costs in our cost-per-visit analysis. Start-up costs are one-time costs that will diminish relative to operating costs over time. Using these costs would have made cost-per-visits initially higher but do not represent the long-term cost-per-visit. Lab costs would have likely occurred even in the absence of the MHCs; i.e. costs associated with processing HRAs and other blood draws would have taken place in the private sector in the absence the centers. To

determine if the MHCs provide health care services at a lower cost when compared to similar service providers, our audit work calculated the average cost-per-visit per MHC by year. These costs are shown below in Figure 2.

Figure 2
Average Cost-Per-Visit Per MHC by Year*



Source: Developed by Legislative Audit Division with HCBD records.

*Includes expenditures relating to lease payments, management fees, salaries, and other overhead expenses.

As shown, since 2013, the average annual costs-per-visit across all MHCs remained relatively stable, ranging between $107 and $113 per year. As expected, because most MHC visits occur at the Helena MHC, that center's average cost is very close to the average overall cost. Conversely, the average annual cost of the MHC in Miles City has continually been significantly higher than the statewide average cost. For example, in 2013 this MHC's cost-per-visit was over 202 percent of the statewide average cost. According to contractor appointment and vacancy reports, since the Miles City MHC opened in 2013, annual vacancy rates have increased from 50 percent in 2014 (its first full year of operations) to 56 percent in 2015. HCBD staff indicated low utilization rates were related to problems with previous medical staff, limited hours of operation, a lack of physicians during all hours of operations, and potential patients in the Miles City MHC service area going to Billings for primary care. Staff from both the contractor and HCBD have stated previous HCBD management required the Miles City MHC to remain open even though the center has been historically underutilized. Interviews with current HCBD management found the division has recently moved

this MHC to a month-to-month lease agreement and is reviewing whether this MHC should continue to operate or would be better served entering into a partnership with a local health care provider.

Health Care and Benefits Division's Calculation of Cost-Per-Visit at the Montana Health Centers Differs From Our Analysis

As discussed, in addition to primary care services, the MHCs also offer wellness services, which are programs intended to improve and promote health and fitness. These services are provided at no direct cost to the state; their costs can therefore be considered to be paid by a portion of the management fee. Wellness services are not included in private sector primary care. To account for this when comparing cost-per-visit at the MHCs to the private sector, HCBD and the contractor subtract a portion of the management fee from their cost-per-visit calculation to account for these additional services. Accounting for noncomparable services in such a manner is defensible, as long as the subtracted portion is reasonable and the costs of the additional services are also disclosed. Our analysis did not include costs related to wellness services, because HCBD does not have access to wellness coaching salary data or to detailed wellness coaching appointment numbers. Without this data, HCBD and the contractor agreed that the marketplace cost of wellness services amounted to $7.09 and $7.41 of the management fee PEPM in 2015 and 2016, respectively. Because HCBD subtracts this part of its management fee from its cost-per-visit calculations, and because it relies on the contractor's reported appointment totals, the division's average overall MHC cost-per-visit is lower than our calculated average. HCBD calculated the average cost-per-visit at the MHCs from 2012 through 2015 to be $73.89, while our analysis, which could not account for wellness services and used EMR data rather than contractor reporting to determine appointment totals, showed an average cost of $111.56 for the same period.

Comparison of Services Between Montana Health Centers and Private Health Care Providers

HCBD contracts with a third-party administrator (TPA) to process health care-related claims that take place in the private sector. HCBD's contracted actuary de-identified all provided TPA claims from 2013 through 2015 for employees and their dependents that are on the State Plan. In order to compare similar services conducted within both private health care providers and the MHCs, we used Current Procedural Terminology (CPT) codes. CPT codes are created by the American Medical Association and consist of a series of numbers used to identify medical and diagnostic services. They are used as a form of communication between health care providers and the payer and/or insurance companies. The codes are used by the payer to pay health care providers for approved services provided to patients.

Most Common Health Care Services Provided by the Montana Health Centers

Audit work consisted of comparing the state's costs for services conducted at private health care providers with similar services done at the MHCs. Our analysis compared the top fifteen most used CPT codes within the MHCs to the same codes in the TPA claims data for State Plan claims paid to private sector medical providers. It is important to note that a health care provider visit can include multiple services. For example, a patient might have visited a provider for an annual physical; however, as part of that appointment the patient might have also received a tetanus vaccination, a flu shot, and a blood draw. Our analysis of the centers' EMR data found that each visit included an average of 3.1 CPT services per visit. The following table shows the 15 most common health care services provided by the MHCs.

Table 5
Top 15 Health Care Services Provided by the Montana Health Centers
(August 2012 through December 2015)

CPT Code	Instances Within MHCs*	As a % of All Health Services Rendered	General Description of Service Provided
36415	52,403	19.5%	Routine venipuncture (A venipuncture is the puncture of a vein with a needle to withdraw blood.)
81002	3,183	1.2%	Urinalysis, by dip stick or tablet
82306	7,885	2.9%	Vitamin D, 25-hydroxy
83036	4,719	1.8%	Hemoglobin; glycosylated
84443	12,309	4.6%	Thyroid stimulating hormone
85025	29,709	11.1%	Complete Blood Count, with differential white blood cell, automated
90471	3,184	1.2%	Immunization administration
90658	9,845	3.7%	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
96372	4,008	1.5%	Therapeutic, prophylactic, or diagnostic injection, specify substance, or drug; subcutaneous or intramuscular
99000	10,346	3.9%	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
99203	4,602	1.7%	Office outpatient new 30 minutes
99204	4,204	1.6%	Office outpatient new 45 minutes
99212	2,844	1.1%	Office/outpatient visit, est. Physicians typically spend 10 minutes face-to-face with the patient and/or family
99213	38,745	14.4%	Office/outpatient visit, est. Physicians typically spend 15 minutes face-to-face with the patient and/or family
99214	19,181	7.1%	Office/outpatient visit, est. Physicians typically spend 25 minutes face-to-face with the patient and/or family

Source: Compiled by the Legislative Audit Division from TPA and HCBD data.

*These services amount to 77 percent of all services primary care rendered at the MHCs.

As shown, 22 percent of the top 15 most used services conducted at the MHCs warranted a CPT code involving lab services (80000 series). Factoring in the procedure to have blood drawn for HRAs (36415), the percentage increases to 41 percent. This means four out of every ten services provided at an MHC involves blood or lab work. This higher percentage of non-primary care services is mostly based on HCBD's incentive program, which rewards the employee and their dependent spouse for receiving an annual HRA, among other activities. If the employee accomplishes all the steps required in the incentive program, they will receive a monthly discount of $30 on their monthly State Plan contribution. (Contributions are similar to premiums paid for insurance coverage.) This incentive totals $360 annually ($720 if the dependent spouse also achieves all the incentive steps). The goal is to increase employee health by catching potentially high-cost health problems before they become problematic.

Charges for Services Provided by Private Health Care Providers

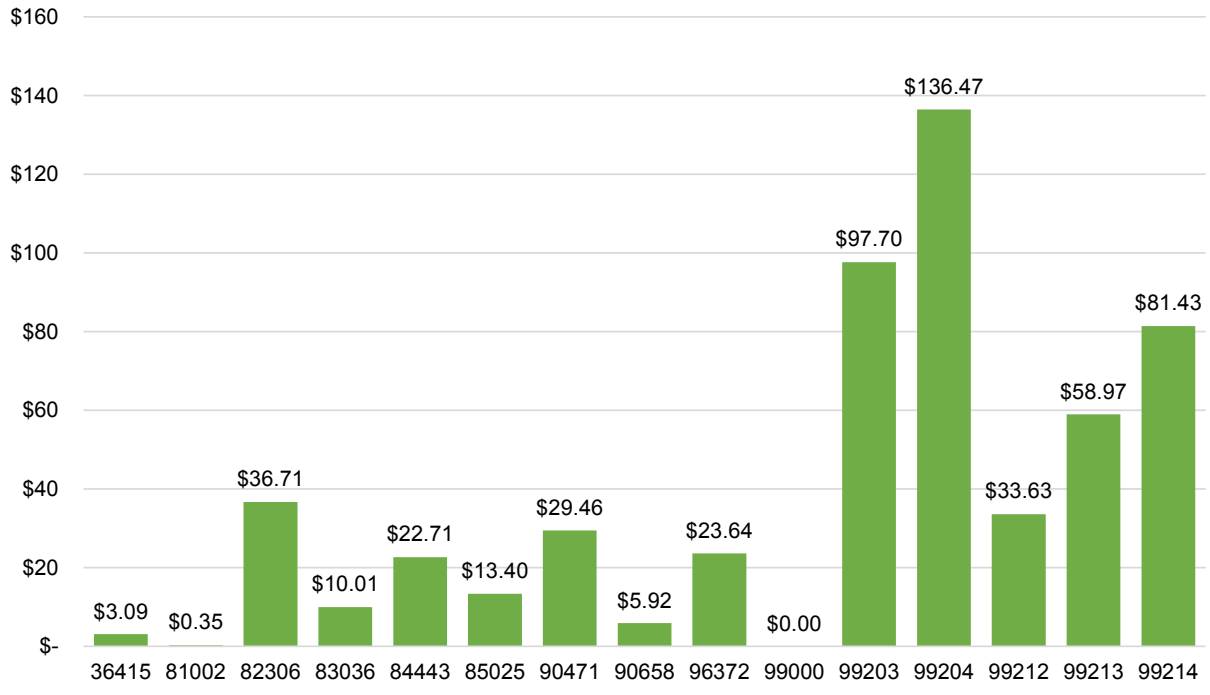
After calculating the average cost-per-visit at the MHCs and determining the 15 most used CPT codes at the centers, we compared these costs to similar services for local private health care providers. Our analysis only included those hospitals and critical access hospitals located in the same cities as existing MHCs (not including Anaconda). Critical access hospitals are found in rural areas that receive federal assistance. We decided to analyze hospitals because they are typically well established in their communities and have been in place for many years. Using CPT code information, we compared average cost-per-visit at the MHCs with the state's average cost for the centers' 15 most common services provided by local health care providers. Charges vary from hospital to hospital based on the agreements in place between the TPA and the hospital. In order to make this comparison, it is important to understand the multiple payers involved when a health service is conducted. These include:

- **Charged Amount:** The charge from a provider for a single CPT code.
- **Allowed Amount:** The total amount a TPA will pay for the service based on the agreement it has with the service provider.
- **Member Paid Amount:** The actual dollar amount the patient paid the provider, dependent on co-pay, coinsurance, and deductible status.
- **Plan Paid Amount:** The actual dollar amount that was paid by the State Plan for the service. The plan reimburses the TPA, which initially paid the provider.

For our analysis we used the plan paid amount because this represents what the State Plan paid for health care services. Our analysis revealed a wide variance of average charges for CPT codes because these codes represent a variety of different services. Our audit work found private health care providers are paid for each service they provide.

Figure 3 shows the state's average cost for these CPT codes across all seven hospitals and critical access hospitals found within the same cities as existing MHCs from 2013 through 2015.

Figure 3
The State's Average Costs for the Top 15 Most Used CPT Codes in Major Hospitals in MHC Service Areas - 2013 Through 2015*
(Not Including the Hospital in Anaconda)



Source: Compiled by the Legislative Audit Division from HCBD records.

*The top 15 most common services conducted at the MHCs.

As shown, there is a wide variance in the average cost of these services. This is to be expected as each CPT code represents a different health care service. It is important to note this is what the state paid for the service, after the employee paid their portion of the service. Through our data analysis and interviews, we found that charges for health care services at the MHCs are recouped differently than at private health care providers. The following section further explains these two different health care business models.

Health Care and Benefits Division Cannot Corroborate Reported Montana Health Center Cost Savings

Based on our review of the cost of health care services (i.e. CPT code data) for MHCs and private health care providers, we determined MHCs and private health care providers operate under different health care business models. Whereas private

health care providers base their revenues on a cost-per-service model, MHC contractor revenue is based on a management fee calculated on state employee populations within MHC services areas.

When a patient goes to a local health care provider, there are likely several services provided during the same appointment. These providers have a separate charge for each of these services, which are then paid by an insurance company/payer, a patient, or both. These costs help pay for the overhead of local health care providers, such as salaries, utilities, supplies, rent, etc., and a mark-up likely applied to make a profit. Under this model, the more services provided, the more revenue received. The state's cost for a private sector patient appointment can be more or less than the average cost of an MHC appointment depending on the types of services rendered. The following provides two possible scenarios of the costs of a visit at a private health care provider versus the cost of an MHC visit. Patient "A" visits a private health care provider for the first time for an initial consultation. As part of this initial 45-minute office visit cost (99204), Patient "A" also had a hemoglobin test (83036) and a complete blood count (85025). When you add the average costs for these three CPT codes together you get a total cost to the state of $159.88, which is more than the average cost-per-visit of $111.56 at an MHC. Patient "B" was an existing patient who had the same two services (83036 and 85025) done at a 10-minute office visit (99212). The costs for these three services would be $57.04, which is nearly half the average cost-per-visit at an MHC.

Conversely, the MHCs operate under a different health care model in which the contractor is paid via a management fee. Currently, the contractor is paid $15 PEPM for the first 5,000 employees under the State Plan that live within the services areas of the MHCs, and $12 PEPM thereafter for all remaining employees living in these areas. Salaries, supplies, and operating costs are paid by HCBD with a $0 markup. Under this health care business model, the contractor is paid the same amount regardless of the number of MHC patient visits.

Ultimately, several factors created a scenario in which we were unable to compare MHC service costs to the costs of similar services done at private health care providers to determine if one entity is ultimately less expensive than the other. These factors include the different health care models, data limitations, and the terms of the existing contract between HCBD and the contractor. Since the MHCs first opened in 2012, various estimates have been reported on how much they could save the state in health care spending on employees over what it would be spending without them. Reports have ranged from $20 million to $100 million over five years. In addition to potentially less expensive costs-per-visit, these estimations include cost avoidance, which are

costs prevented due to employees being diagnosed as at-risk for specific diseases or conditions and proactively addressing these issues, thereby avoiding the disease and its future costs. According to HCBD management and industry professionals, the contractor's avoidance cost calculations are not rigorous or accurate. Because it is not possible to compare the costs of these different models per-visit or service, and because any avoidance costs are not reliable, any specific claims of health care savings cannot be corroborated.

Montana University System Questions Montana Health Center Cost Effectiveness

Montana University System (MUS) staff have a health care plan that is separate from the plan state employees use. We interviewed MUS staff to get their opinion on the MHCs and found they question the cost effectiveness of the MHCs. For example, they believe the HRAs done at the MHCs are more expensive than HRAs available under the MUS health plan. MUS currently does have a pilot program in place in which Helena College of Technology employees can use the Helena MHC. However, MUS staff believe the health benefits available under their health care plan are more cost effective than services offered at the MHCs. Overall, they think the MHCs are geared toward long-term savings as these centers help employees and dependents, who have not seen a doctor in years, deal with potential costly diseases such as diabetes. Accordingly, it is their belief it will take five to ten years to see the benefits in regards to lower costs, of treating these higher-risk employees.

Two goals listed in the RFP were to improve health outcomes for plan members and to improve treatment and compliance for patients with chronic health conditions. The MHCs may accomplish these goals eventually, but these are long-term goals. If MHC patients are found to be at risk for health problems, such as high cholesterol or diabetes, and these patients then make life changes to prevent potential serious health problems, the state could save money in the long-term. However, these are not short-term fixes, and therefore would not be responsible for short-term reductions in health care costs. Another MHC goal is to reduce costs for the State Plan and plan members. There is a cost reduction for plan members if they visit an MHC because they do not pay co-pays or deductibles for health care services received at the centers. While this saves out-of-pocket expenses for individual members for MHC visits, there has not been a reduction in monthly contributions paid by State Plan members.

Conclusion

The Montana Health Centers and private health care providers operate under different health care business models. As a result, the Health Care and Benefits Division cannot demonstrate if the Montana Health Centers are providing health care services at a lower cost when compared to similar service providers.

The Benefits Associated With Operating the Montana Heath Centers

The first part of this chapter related to the costs associated with operating the MHCs. The focus will now shift to how these costs eventually benefit the state and its employees. To better understand any potential benefits, audit work determined the overall use and satisfaction of the MHCs through a survey of approximately 12,400 Executive and Judicial Branch state employees in August 2016 that were members of the State Plan. In all, 4,061 employees responded for a response rate of 33 percent. This survey helped us better understand how many employees are using the MHCs, what services they are seeking, the reasons they use the centers, and how satisfied they are with the quality of care they receive. The following sections outline our findings.

Employees' Perspective of the Montana Health Centers

As part of our audit work we wanted to find out how many state employees are using the MHCs, how often, what services they are seeking from the centers, why they choose the centers, and their overall satisfaction levels. HCBD staff stated they want employees and their dependents to consider the MHCs as their primary care providers. Using the employee survey results, we found 82 percent of survey respondents or their dependents had visited an MHC since the first center opened in 2012. We then asked those employees who have used the MHCs how many visits they and/or their dependents had in the past 12 months, which is shown in Table 6.

Table 6
Number of Times Patients Used the Montana Health Centers in the Past Year

Answer Options	Response Percent
1 time	11.8%
2 to 5 times	61.1%
6 to 9 times	17.1%
10 or more times	7.2%
Patient has not visited an MHC in the past 12 months.	2.7%

Source: Legislative Audit Division survey.

As shown, 73 percent of respondents that have visited an MHC in the past say they visit a center up to five times a year, with another 17 percent using them six to nine times a year. As discussed, patients can use the MHCs for three reasons: HRAs, primary care needs, and wellness coaching. Table 7 shows this use by MHC patients.

Table 7
Health Services Used by Patients at the Montana Health Centers

Answer Options	Response Percent
Annual health risk assessment	91.5%
Primary care services	79.5%
Health/wellness coaching	36.2%

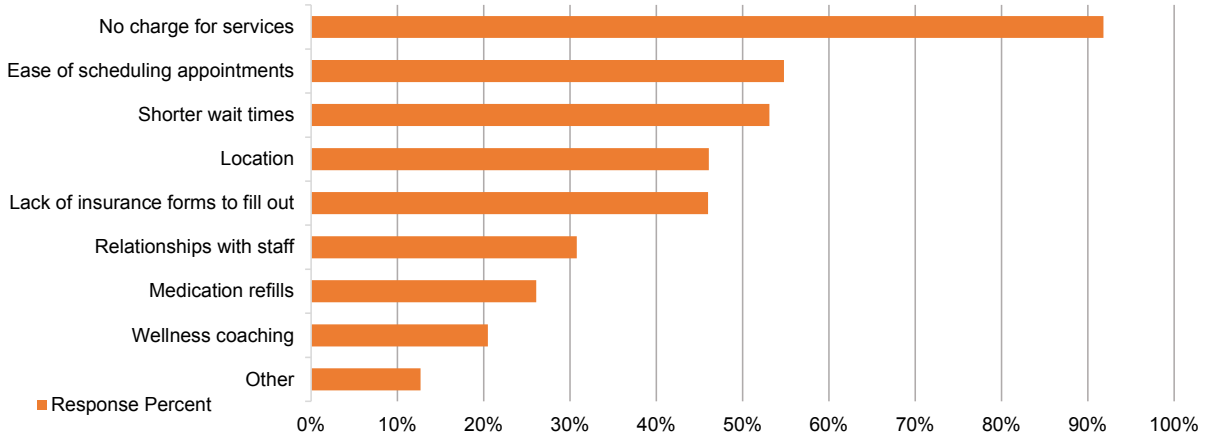
Source: Legislative Audit Division survey.

Nearly 80 percent of respondents that visited an MHC sought primary care. Also, approximately 92 percent of these respondents used the MHCs to get their HRA. This is required for employees and their spouses to qualify for HCBD's annual incentive program, which reduces the employees' monthly State Plan contribution. Fifty percent of those employees who had an HRA discovered a health care concern, such as high cholesterol or diabetes, which needed additional care. Of these respondents, 82 percent sought additional care at either an MHC or an outside health care provider. Although HCBD does not have hard data on improved health outcomes, these survey results indicate some employees have improved awareness of their health.

When asked why employees and their dependents use the MHCs, the most frequent response was the lack of co-pay required for services, as compared to the $25 to $35 co-pay required for an in-network private primary care physician or specialist and an urgent care visit, respectively. Figure 4 illustrates the main reasons employees use MHCs, based on employee survey responses.

Figure 4

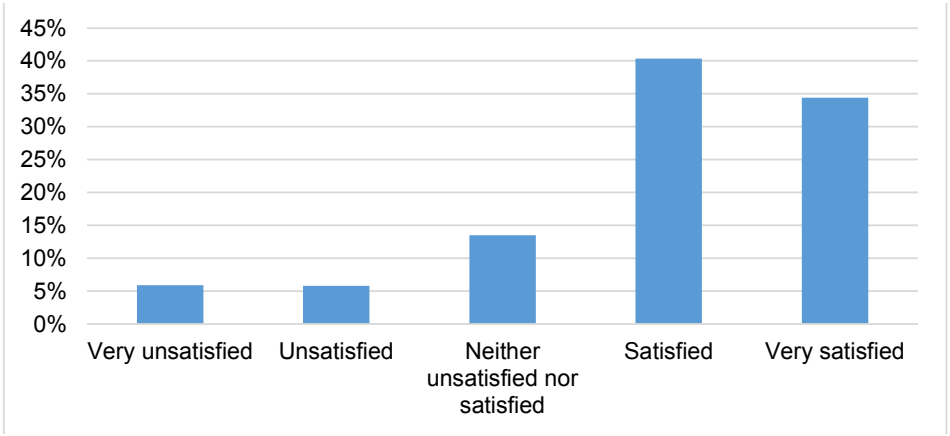
Reasons Employees and/or Dependents Use the Montana Health Centers



Source: Legislative Audit Division survey.

There are a number of reasons employees use MHCs instead of local health providers. However, more than 90 percent of survey respondents indicated they use the MHCs because there is no charge associated with the visits in the form of co-pays or deductibles. MHC location, shorter appointment wait times, ease of appointment scheduling, and lack of insurance/payer documentation are other reasons patients visit the centers. The survey also allowed us to gauge the overall satisfaction levels of those patients that have used the MHCs, which is displayed in Figure 5 (see page 25).

Figure 5
Overall Satisfaction of Quality of Care Given at the Montana Health Centers



Source: Legislative Audit Division survey.

Seventy-four percent of survey respondents who reported visiting an MHC in the past indicated they were satisfied or very satisfied with the overall quality of care they received, with 12 percent being unsatisfied or very unsatisfied. These results tie into the overall thoughts of the respondents, in which 92 percent said they wanted the state to continue to operate the MHCs.

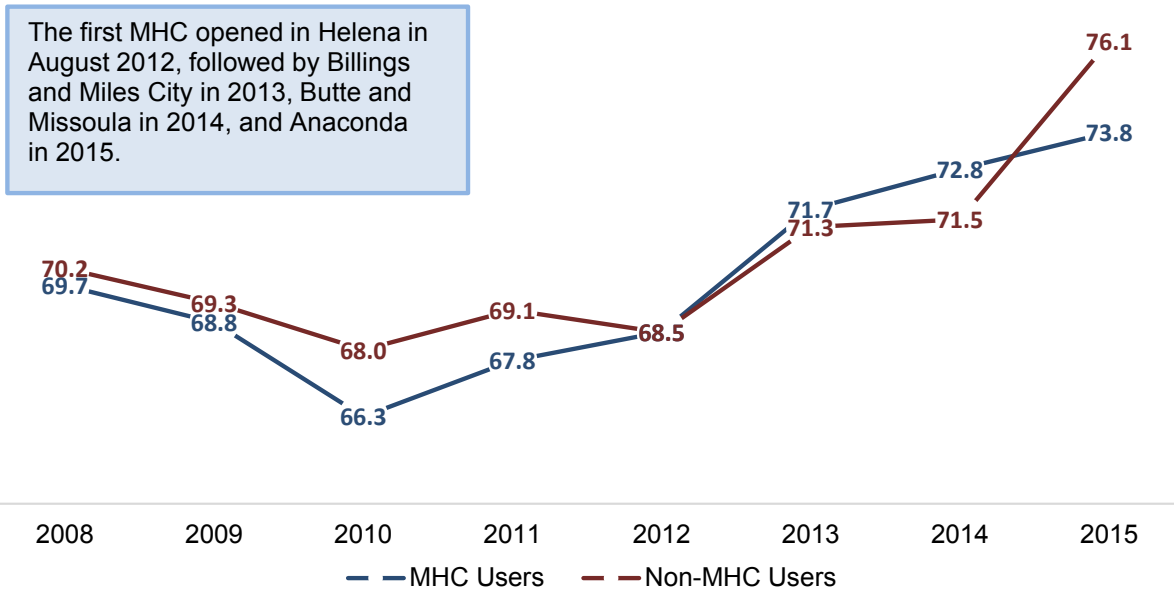
Montana Health Centers Have Not Achieved Goal of Reducing Employee Absenteeism

Alongside the benefits to employees attributed to the MHCs, we also wanted to determine the benefit to the state. Ultimately, the MHCs are in place to improve patient health and to save the state money in relation to health care costs. One way to measure this is through reduced absenteeism. If the MHCs are functioning as intended, then state employees should be healthier, and as a result, use less sick leave. This is in line with one of the goals of the MHCs, which is to "Improve employee productivity and reduce absenteeism." In the contractor's RFP response, it also stated it would save the state money by increasing productivity and reducing time away from work. The goal to improve productivity is not something we could analyze, because there is not a baseline at which to compare productivity both before and after the implementation of the MHCs. As part of our audit work, we recognize we do not know the reasons employees use sick leave hours; i.e. taking care of sick dependents or family members, FMLA, themselves being sick, etc. There are certainly circumstances in which an employee's sick leave hours might be considerably higher from one year to the next for unforeseen circumstances. However, audit work did include evaluating the

reduction of absenteeism through the analysis of sick leave hours used by employees that use the centers compared to those that do not.

Through the use of the Statewide Accounting, Budgeting, and Human Resources System (SABHRS), we pulled sick leave use by quarter for state employees who are members of the State Plan and state employees who are not members of the State Plan, and who were continuously employed on a full-time basis (40 hours a week) from January 1, 2008, through December 31, 2015 (this did not include MUS employees, whom are covered under their own health care plan). This constituted a total of 6,091 employees. We evaluated their use of sick leave both before and after the MHCs opened in 2012. Figure 6 breaks down this analysis by showing the annual average number of sick leave hours used by both MHC users and nonusers from 2008 through 2015, so we could track sick leave use both before and after the MHCs opened.

Figure 6
Average Sick Leave Hours Used for MHC and Non-MHC Patients*



Source: Compiled by the Legislative Audit Division from SABHRS and contractor EMR data.

*Covered by State of Montana Benefit Plan from 2012 through 2015.

As the figure shows, the amount of sick leave hours used by our cohort MHC users and nonusers has remained similar since 2008, with average use climbing since 2012. However, contrary to the RFP's stated goal, the implementation of the MHCs has not resulted in a reduction in absenteeism for this group of employees relative to non-MHC

users. Table 8 further analyzes the average number of sick leave hours between these MHC users and nonusers both before and after the centers opened in 2012.

Table 8
Average Annual Sick Leave Hours Used by Montana Health Center Users and Nonusers*

MHC Use	Total Employees	2008-2011	2012-2015	2008 - 2015
Do Not Use MHCs	1,795	67.2	69.8	68.5
Use MHCs	4,296	68.8	71.3	70.0

Source: Compiled by the Legislative Audit Division from SABHRS and contractor data.

*The first MHC opened in Helena in August 2012.

As shown, although minimal, MHC users average more sick leave hours used than nonusers do. As part of our employee survey, we asked employees who have visited an MHC if their sick leave use has changed since the MHCs have opened. In response, 64 percent of respondents stated their usage has stayed about the same, which aligns with results found in our analysis. Interviews with HCBD staff found they have not analyzed employee absenteeism related to MHC participation because they determined there was not an accurate way to do so.

Health Care and Benefits Division Should Implement an On-Going Review Process of the Montana Health Centers

In March 2014, HCBD's contracted actuary conducted an review of the Helena MHC using 2013 patient data. This review covered access to health coaching, and the MHCs effects on local emergency rooms and urgent care centers, chronic health conditions, and health care costs. A follow-up review by the same actuary using 2014 data was to be completed in early 2016, but was cancelled and never completed. An additional consultant that specializes in employee health clinics was supposed to audit the MHCs using 2014 data to determine if increasing costs for MHC services are offset by savings elsewhere. However, this audit was also canceled. As a result, HCBD has only had one actuarial review of the Montana Health Centers, and that occurred three years ago when only one MHC was in operation. As discussed, the MHCs have cost over $26.1 million to operate since 2012, and HCBD needs to determine if MHC benefits outweigh the costs. Regular cost assessments from independent consultants specializing in employee health clinics will help HCBD ensure the MHCs are a benefit that should continue for employees and their dependents. In addition, HCBD should develop in-house methodologies to create a cost comparison of services provided at MHCs with similar services at local health care providers.

Interviews with HCBD staff found they view the MHCs as a means of implementing a value-based design (VBD) model of health care delivery. Unlike a cost-for-service model, the VBD model aims to increase health care quality and decrease costs by using incentives to encourage cost-efficient health care services and choices. According to the National Conference of State Legislators, the VBD model centers on covering preventive care, wellness visits, and treatments to control blood pressure or diabetes at low to no cost, which would ultimately save money by reducing future expensive medical procedures. Additionally, VBD model plans may include disincentives, such as high cost-sharing, for health-related choices found to be unnecessary or repetitive, or when the same outcome can be achieved at a lower cost. HCBD staff stated they are working with the contractor to fully integrate the VBD model.

RECOMMENDATION #2

We recommend the Department of Administration develop a process to independently and accurately compare and report health service costs and benefits of the Montana Health Centers to similar services, including those:

A. *Provided by local health care providers under a cost-per-service model, and*

B. *Provided under a value-based design model.*

Chapter III – Impacts on Local Health Care Providers

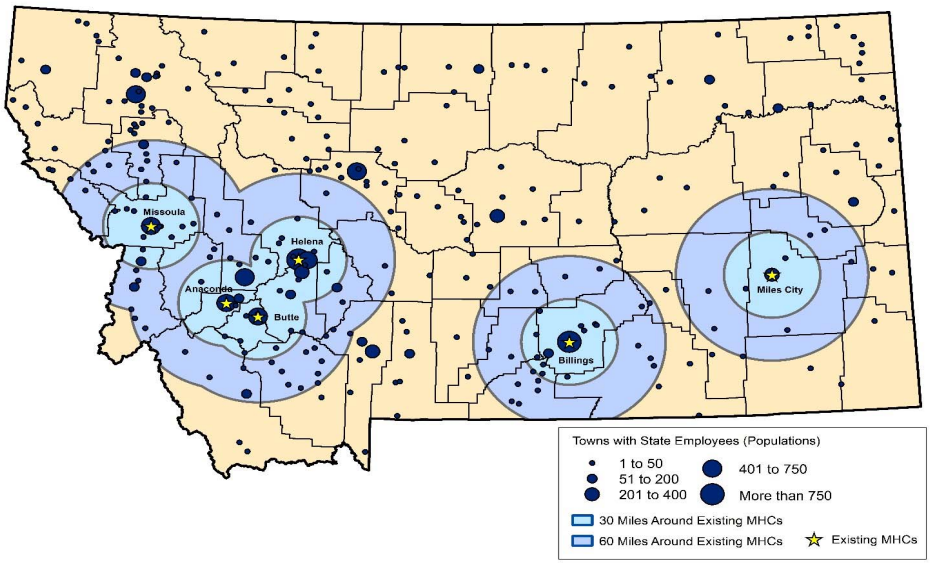
Introduction

According to staff at the Department of Administration's (DOA) Health Care and Benefits Division (HCBD), the Montana Health Centers' (MHC) contractor, and the Montana University System (MUS), there has been a shortage of primary care physicians in Montana. This shortage often caused employees and their dependents to wait for long periods for appointments, or put off primary care altogether. To help address this problem, the first MHC was opened in August 2012 under the direction of the HCBD. One of the goals for opening the MHCs was to increase access to primary care services for state employees and their dependents. When the MHCs were created there were questions from stakeholders about how these centers could ultimately impact local health care providers in those areas where centers are located. One of the objectives of this audit was to determine what, if any, impacts the MHCs had on local health care providers. As part of our audit work, we evaluated state employee access and use of the MHCs and how this has impacted local health care providers located in those areas. Our work found that since the implementation of the MHCs, other health care providers in those areas have reported a decrease in the number of patients with private health insurance as well as a disruption of care between patients and health care providers. This chapter discusses our audit work and outlines the need for HCBD to improve coordination with local health care providers in areas where MHCs operate.

Employee Access to Montana Health Centers

In order to better understand any potential impacts to other providers, we needed to determine how many employees have reasonable access to the MHCs and how many are using them. Per the contract between HCBD and the contractor, MHCs have an established service area based on surrounding ZIP codes, which could be over 100 miles from a center in some cases. Consequently, we mapped the locations of the MHCs and the home address ZIP codes of a cohort group of employees to get a better understanding of where those who use the centers are coming from. This group included those employees continuously employed by the state from January 1, 2008, through December 31, 2015, that visited an MHC. We also obtained the home ZIP codes for all state employees as of October 31, 2016, using the Statewide Accounting, Budgeting, and Human Resources System (SABHRS) system. As part of our work, we documented how many employees live within 30 and 60 miles of the centers. These ranges were chosen because there are not established service area distances defined in the MHC contract. Figure 7 (see page 30) shows these results.

Figure 7
Employees Within 30 and 60 Miles of an Existing Montana Health Center



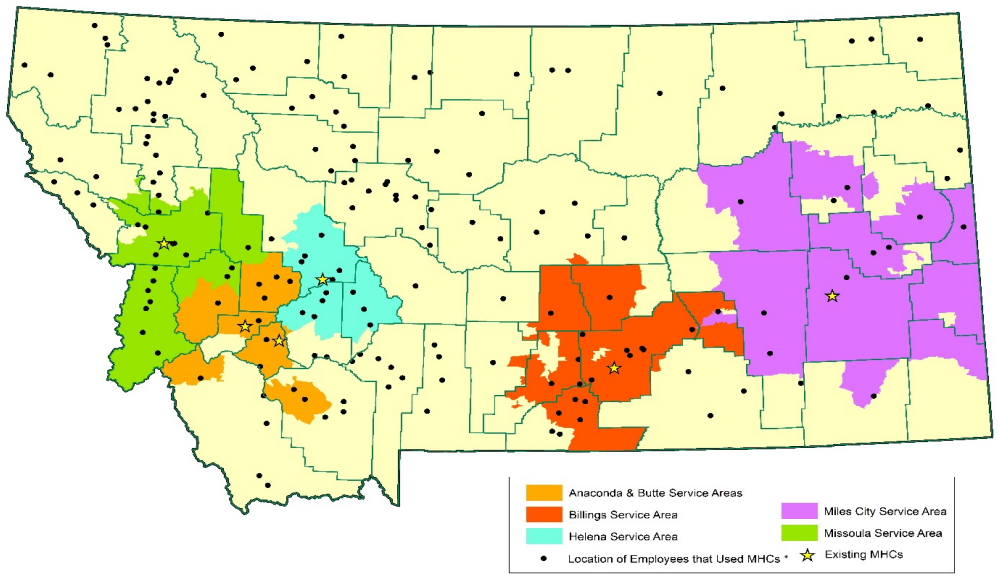
Source: Compiled by the Legislative Audit Division using GIS software and SABHRS records.

As shown, presently the MHCs cover state employees in most of the higher employee-populated cities in Montana, and one less populated area (Miles City). It also shows that three of the six MHCs (Anaconda, Butte, and Helena) overlap when looking at those employees within a 30 miles radius of an MHC, meaning that some of these employees could more reasonably access several MHCs without having to travel more than 30 miles. With the exception of Miles City MHC, which has fewer than 300 employees within a 30-mile radius, all other MHCs have over 900 employees within 30 miles.

Many Employees Do Not Have Access to the Montana Health Centers

Audit work found many state employees cannot reasonably access an MHC even though a portion of their monthly contributions for the State of Montana Benefit Plan (State Plan) funds the centers. As a result, these employees have to pay out-of-pocket costs (i.e. co-pays and deductibles) to receive health care at local providers. When employees were surveyed, 22 percent of respondents said they lived 60 miles or more from the closest MHC. Figure 8 (see page 31) shows the service areas for the existing MHCs, which are established in the contract between HCBD and the contractor, and are based on surrounding ZIP codes. The figure also shows the home ZIP code of all our cohort employees.

Figure 8
Montana Health Center Service Areas



Source: Compiled by the Legislative Audit Division using GIS software and SABHRS records.

The contractor is paid a management fee based on the number of employees covered under the State Plan living within the service areas of each MHC. Specifically, the contractor is paid $15 per-employee-per-month (PEPM) for the first 5,000 employees, and $12 PEPM thereafter. As shown, the size of MHC service areas vary. For example, the service area for Miles City is much larger than the service area for Helena–some towns within this service area are nearly 140 miles from Miles City. The size of the service area has a direct impact on the management fee paid to the contractor because the larger it is, the more employees it will encompass. With that being said, the MHCs may not be reducing costs for those employees and dependents that are traveling far distances to a center. Between having to take additional sick leave to travel, and associated travel costs, these employees are likely paying more out-of-pocket than the money they save by not having to pay a co-pay at an MHC.

Montana Health Centers Expanded Without Proper Planning

Audit work found HCBD expanded the MHCs without a growth strategy. Such a strategy would include a cost-benefit analysis and identifying where larger state employee populations are throughout the state. The Helena MHC opened in August 2012, followed by MHCs in Billings and Miles City in 2013, Missoula and Butte in 2014, and Anaconda in 2015. After Helena opened, four other centers opened in less than

30 months. The original Request for Proposal (RFP) contained the following: "the State will work with the selected vendor to evaluate statewide expansion and anticipates the possible opening of additional On-Site Employee Health Centers during the contract period as the program matures." However, the RFP was later amended before responses were due to indicate that MHCs will be expanded without requiring analysis on how effectively the MHCs were operating and if expansion to other cities around the state made sense. Specifically, the amendment to the RFP indicated "the State will work with the selected vendor to evaluate statewide expansion and anticipates completing the identification and evaluation of locations for at least two additional sites by the end of 2012, and intends to open Health Centers in these locations in early 2013. The state then will work with the contractor to complete additional site evaluations with the intent to open additional On-Site Employee Health Centers during 2013, 2014 and 2015." Since the implementation of the centers, HCBD management has changed and current staff said they believe expansion occurred too quickly.

One of the first two expansion MHCs was in Miles City, which has continuously experienced high appointment vacancy rates and a high cost-per-visit since it opened. For example, in 2015 the vacancy rate at this MHC was 56 percent and the center's cost-per-visit was 202 percent of the statewide average cost. Interviews with HCBD staff indicate the MHC was opened because prior DOA staff believed it was important to serve employees in eastern Montana. Interviews determined expansion decisions were based solely on concerns that it would be perceived as unfair if an MHC was not opened on the eastern side of the state. Additionally, MHC clinical staff said that operating a standalone MHC in Miles City does not make sense because the population is too low; there are fewer than 300 state employees within 30 miles of Miles City and fewer than 400 within 60 miles. Instead, they think a partnership with a local health care provider may be a better option.

Meanwhile, the Butte MHC was the last of the five standalone centers to open. Audit work found there are more than 2,000 state employees within 30 miles of Butte and more than 8,100 within 60 miles. Upon opening, the utilization rate was high enough that the partnership with the hospital in Anaconda was initiated to meet the demand for service in the area. Even after this partnership, the Butte MHC still has the highest rate of use of all MHCs. It also provides the second-highest overall number of appointments. While this MHC has turned out to be successful in terms of usage, given the high use of this center, good data could have determined this center should have been opened prior to opening other centers around the state.

Other States Use More Methodical Approach for Expansion

Interviews with staff in other states indicate a more methodical approach to assessing the operation of an employee clinic over multiple years before expanding is optimal.

For example, New Mexico initially planned on opening two additional clinics outside of Santa Fe. However, due to concerns about performance and data availability, the state has put off such efforts until it has better information. Tennessee has also decided not to expand the number of clinics until it has a return-on-investment study done on its existing clinic in Nashville.

Distance From a Montana Health Center May Contribute to Primary Care Provider Decision

We analyzed those employees that have used an MHC in the past to determine how many miles they lived from the nearest center. The following table shows MHC use and distance between the employees' hometowns and the nearest MHC.

Table 9

Distance Between Hometowns and Nearest Montana Health Center of Those Employees That Visited Centers Between August 2012 and December 2015

Miles	Total Employees*	Total Employee Visits	Percentage of Visits
0 to 9 miles	1,842	34,412	67.8%
10 to 25 miles	311	4,968	9.8%
26 to 50 miles	181	2,870	5.6%
51 to 75 miles	203	2,619	5.1%
76 to 100 miles	254	2,931	5.8%
101 to 150 miles	189	2,424	4.8%
More than 150 miles	52	553	1.1%
Totals	**3,032**	**50,777**	**100%**

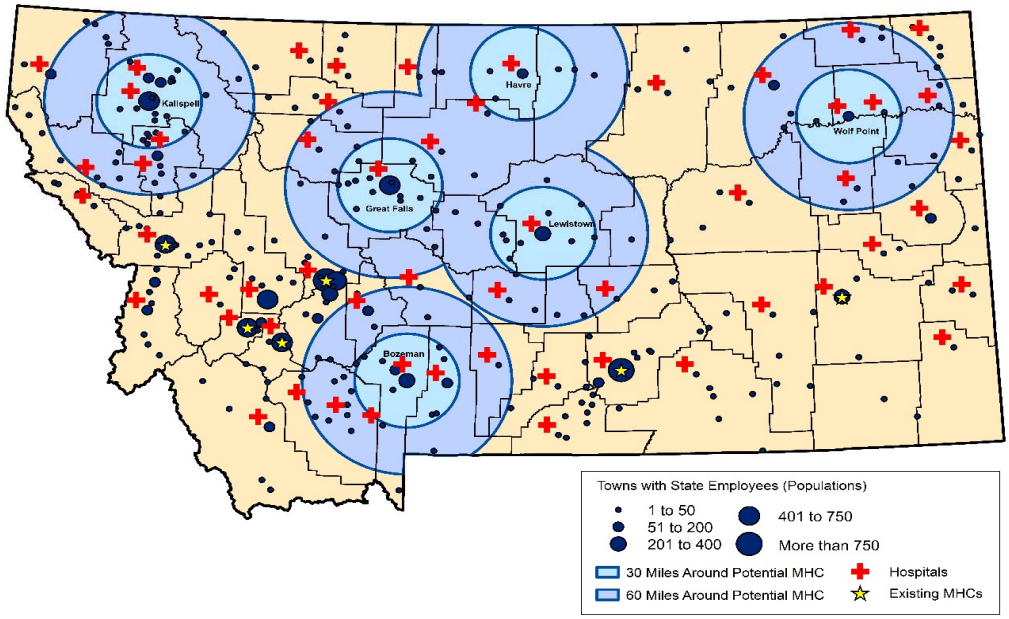
Source: Compiled by the Legislative Audit Division from SABHRS and contractor EMR data.

*Of 6,091 employees continuously employed on a full-time basis between January 1, 2008, and December 31, 2015. The 3,032 employees represent those that visited an MHC, as based on contractor data.

As shown, 78 percent of the employees in this group lived within 25 miles of an MHC. According to HCBD staff, a goal of the MHCs is for employees to consider the centers as their primary care provider. Employee survey results found 36 percent of respondents that have used an MHC do not consider the centers as their primary care provider. The survey also found 18 percent of respondents never visited an MHC despite being a member of the State Plan. The majority of these respondents said they never visited an MHC because there was not one close to where they lived. Other reasons included: employees already had a primary care provider, uncertainty as to the kinds of health care services MHCs provided, MHC operating hours were not convenient, and lack of confidence in MHC staff.

Audit work found several areas around the state with high state employee populations located more than 60 miles from the nearest MHC. The figure below shows cities and their surrounding areas with high numbers of state employees that do not currently have an MHC near their residence. In addition, this figure also shows the location of all hospitals and critical access hospitals throughout Montana that employees in these areas may be using to receive at least some of their health care services.

Figure 9
Areas Without Montana Health Centers



Source: Compiled by the Legislative Audit Division using GIS software and SABHRS records.

There are a number of cities that have a large number of state employees without an MHC. These include Bozeman, Great Falls, Havre, Kalispell, Lewistown, and Wolf Point. For example, Bozeman has almost 500 state employees living within 30 miles of town and Kalispell has over 800 employees. Additionally, HCBD staff stated that in the 2016 plan year employees on the State Plan had an average of 2.1 dependents on the plan. Therefore, an area like Bozeman could actually represent approximately 1,700 State Plan members living within 30 miles. According to HCBD staff, there are no MHC expansion plans currently in place as it is evaluating center operations. All these areas have hospitals or critical access hospitals in place that could be considered for potential partnerships for any future MHC expansion plans.

Partnerships Between the Contractor and Local Health Care Providers–The Anaconda Model

Upon opening in 2014, the Butte MHC experienced high utilization rates. As a result, HCBD determined the region could sustain another part-time MHC. HCBD asked the contractor to partner with the local hospital in Anaconda and the two opened an MHC in an existing hospital clinic in the spring of 2015. This MHC is open two days per week and is staffed by hospital-employed providers. The contractor agreed to collect no additional management fee for this MHC because it exists within the service area of Butte's center. The contractor is obligated to pay the hospital $12.50 per hour for the 16 hours per week the center is in operation for use of the facility. This cost covers rent, equipment, utilities, and building services. The contractor then invoices HCBD these charges as pass-through costs with $0 mark-up. The contractor also invoices HCBD for salaries, lab costs, and supplies as pass-through costs.

HCBD staff stated there are differences in the business model when partnering with private health care providers. For example, the Anaconda private health care provider staff are paid at higher rates than other MHC staff because they are hospital staff, and the private provider had to get used to longer appointment times with patients. Both HCBD and contractor staff report collaborations with local hospitals can be difficult because of conflicting models. Whereas it is the contractor's priority to provide primary and wellness care to prevent as many downstream costs as possible, HCBD and contractor staff report the role of hospital primary care staff is to serve as gatekeepers to specialists, which generate greater revenue for the hospital. However, contractor staff stated the current partnership has worked well and hospital staff have bought into the mission of providing primary and preventative care. However, there were some logistical issues; staff require training in contractor protocols and software, and using existing hospital systems and technology in alternative ways can cause challenges not faced at other MHCs. HCBD and contractor staff at both the corporate and MHC level are not opposed to similar future collaborations with local health care providers, but stated that such collaborations would need to be targeted to areas where providers were willing to accept the contractor's model.

It is important to note that because HCBD does not pay the contractor a management fee for the Anaconda MHC, as it already exists within the service area of the Butte center, this center is not a true representation of how future partnerships would operate elsewhere. For example, if the Miles City MHC became a partnership, the state would presumably pay a fee similar to the Anaconda fee to cover other operating costs, plus an additional management fee. The partnership would save the state lease costs and other overhead, but it is unknown if the MHC staff would refer patients to specialists

at a higher rate, which could cost the state more money in the short-term. Without complete and accurate data, it is difficult to develop a meaningful comparison.

Audit Surveys Found Local Hospitals Are Open to Partnerships

Audit work also consisted of surveying hospitals and critical access hospitals located within the service areas of existing MHCs. In all, administrative staff at 21 hospitals and critical access hospitals were surveyed, with 16 responding for a response rate of 76 percent. Survey results found 75 percent of the respondents were in favor of partnerships, some stating it would improve coordination of care for patients and be more convenient for state employees and their dependents living in those areas. Along with primary care, 69 percent of the hospitals also offer health risk assessments (HRA), and 62 percent offer wellness coaching, which could include nutrition, exercise, behavior, and/or nursing coaching–services that exist within the MHCs. Furthermore, based on our employee survey, 96 percent of respondents stated they have a health care provider located in their area.

RECOMMENDATION #3

We recommend the Department of Administration:

A. *Clearly define, in a growth strategy, criteria for any potential future expansion of the Montana Health Centers that addresses state employee populations, and partnering with local health care providers where expansion is feasible, and*

B. *Determine if the Miles City Montana Health Center should be closed or partnered with a local health care provider.*

Montana Health Centers Have Impacted Local Hospitals

Our survey of hospitals and critical access hospitals found there have been impacts to hospitals located near MHCs. Seventy-five percent of our hospital survey respondents stated they offer primary care and 88 percent stated they offer acute care–two services also provided by MHCs. When asked if the implementation of the MHCs had an impact on their hospital, 50 percent answered in the affirmative, with five of those located in the same city as an MHC. Overall, the survey responses indicated the two primary ways in which MHCs have impacted hospitals are:

1. Decreasing the number of patients with the state's health care plan using hospital service, and
2. A subsequent disruption of care between the patient and the provider.

Eighty-eight percent of hospital survey respondents also stated they have seen a reduction in the number of private insurance payers once an MHC opened in their service area. HCBD wants members of the State Plan to consider the MHCs as their primary care provider. Our employee survey found 59 percent of those that have used the MHCs considered it to be their exclusive primary care provider. Furthermore, 67 percent of these employees who stated they exclusively use the MHCs said they had an existing outside primary care provider before they switched to the centers. As a result, according to survey results, fewer state employees and their dependents are visiting local health care providers, and are instead seeking primary care at an MHC. This reduction in state employee patients, consequently, has reportedly resulted in a change to the hospital's overall payer mix.

Montana Health Centers Impacting Hospital Payer Mix and Revenues

Typically, a hospital's payer mix consists of Medicare, Medicaid, private insurance/state health care plan, private pay, and charity care (donated services). Historically, Medicare and Medicaid reimburse hospitals at levels below what private insurers pay. The payer mix can be disrupted if MHCs are pulling state employees away from hospitals and into the centers. Therefore, the amounts billed by hospitals could potentially increase at hospitals when private insurance payments are reduced because the ratio of Medicare, Medicaid, and private pay patients increase. According to our hospital survey, all of the respondents that said their payer mix was impacted also stated their private insurance patients decreased. One local hospital stated its Medicare/Medicaid mix increased by 11 percent and its private insurance payer mix decreased by approximately 9 percent since an MHC opened in their area. Hospitals generally have three options to combat a shift in payer mix that results in a loss of revenue: control costs, reduce staff, or increase service fees (or a combination of all three). In response to seeing a decrease in private insurance payers, 71 percent of hospitals surveyed reported they reduced staff, while others stated they reduced or eliminated services, or increased patient charges. Although there has been a decrease in state employee and dependent patients, local providers and hospitals stated the larger problem associated with the MHCs is the use of the contractor's electronic medical record.

Electronic Medical Records Missing Key Patient Data

An electronic medical record (EMR) is a digital version of a paper chart that contains all of a patient's medical history from one practice. The EMR is mostly used by providers for diagnosis and treatment purposes. Some of the benefits an EMR has over a paper medical record is that it can track data over time, identify patients who are due for preventative screenings, and monitor certain patient parameters, such as blood pressure readings. Ideally, an EMR can be shared among providers to help support continuity

of care and reduce duplication of services. Most health care providers use an EMR and there are several EMR software packages on the market. Unfortunately, differing EMRs do not always communicate seamlessly with one another. When HCBD issued the RFP for the MHCs, one of the requirements of the eventual vendor was that its EMR be accessible to the state, providers, and employees. Since the creation of the MHCs, the contractor's EMR has been a concern for HCBD, state employees, and several health care stakeholders.

The contractor uses its own in-house, proprietary EMR. According to contractor staff, they prefer to use their own EMR because it is designed for their model of care rather than for a fee-for-service model. The contractor's RFP response states the EMR is "documented with all patient activity and fosters a collaboration with internal (contractor) staff as well as outside providers to create a patient-centered medical home." The RFP further states the contractor has the ability to send and receive data to outside providers and facilities and can grant EMR access to authorized providers so they can share the patient's health record. In addition, MHC clinical staff, case managers, and health and wellness coaches are supposed to communicate with outside providers to provide for the best coordination of patient care. However, interviews with multiple stakeholders found that coordination of care is often not occurring. According to MHC interviews, the contractor has issues both sending and receiving EMRs from other providers. This is contrary to the contractor's RFP response, which stated its EMR "has the ability to send and receive data to other health care practitioners." Interviews suggested this was because the contractor's EMR was built in-house, so it cannot be shared with other entities. Contractor staff also stated the EMR is not easy to navigate, which makes it difficult to find needed information, such as immunization records or the dates of specific patient services. Our interviews also found the contractor's EMR does not communicate with other EMRs, "doesn't have a whole lot of functionality," and "is not conducive to chronic care." One MHC employee stated there have been some improvements lately that are encouraging and the contractor is continuing to implement new updates, often at HCBD's demand.

Communication Between the Contractor and Local Hospitals Needs Improvement

The inability to effectively share EMRs between MHCs and other providers was echoed by health care providers and hospitals within the service areas of existing centers. Eighty percent of respondents stated 1) they had difficulties reaching MHC staff to make a records request, and 2) there were system compatibility issues with the centers' EMRs. Our survey also addressed questions on how effectively hospitals communicate with MHCs regarding patient care. The majority of hospitals responding to our survey indicated difficulties in getting information from an MHC. This included health care

providers never receiving patient health records and EMR system compatibility issues with MHCs.

A comment from a survey respondent stated their patients usually assume the provider already has access to their Montana Health Center EMR, so they do not bring a hard-copy file with them. This results in a delay in services as a request has to be made to the MHC. Our employee survey also found 15 percent of those patients who requested an EMR transfer between an MHC and another provider encountered problems. In addition, eight percent of survey respondents indicated they had problems when they requested their local health care provider transfer EMRs to an MHC. Our employee survey also found 15 percent of those patients who requested an EMR transfer between an MHC and another provider encountered problems. These included taking too long to send the EMR, the provider never receiving the record, or the record being incomplete or unusable by the provider.

Interviews with MUS staff found they believe there has been a disconnect between the MHCs and local health care providers. Staff stated they think the overall health of a person is attributable to having a patient go to their primary care physician and then being referred to specialists that can pinpoint and work with health concerns. However, this system requires a strong relationship between the hospital/clinic and its specialists. MUS staff believe the MHCs could sever the relationship between hospitals and their specialists as they are not actively working with the centers. This is among the reasons MUS has elected not to have most of its university units participate with the MHCs to provide health care for their employees.

One of the primary impacts to local health care providers has been poor communication between MHCs and local health care providers. The contractor is not unique in this situation as there are several major EMRs on the market, and these EMRs do not always communicate effectively with one another. Nonetheless, the contractor's EMR, and the problems associated with it, does tie into a larger, more systematic impact to local providers, which leads to a disruption of care between local providers and their patients.

There Is a Disruption of Care Between the Montana Health Centers and Hospitals

Because the contractor's EMR does not integrate with the EMRs of other health care providers, there is often a lack of communication between these two entities. According to follow-up interviews with staff that took our survey, they are discouraged because they do not know what is happening with their patients when they are having services done at the MHCs. When patients go back and forth between private providers and

the MHCs, neither provider has a good understanding of what the other has done. According to surveyed staff, this may lead to duplication of services and labs, which is inconvenient and costly, and leads to delays in needed health care services. Delays in services result because patients often do not realize that their providers (both private and at the MHCs) do not communicate or share EMRs thoroughly and effectively. HCBD is aware of these issues and is working to try to improve how communication occurs between the MHCs and private providers. Since this is an issue that directly affects patient care and can lead to increased and unnecessary costs for both patients and private providers, HCBD should make resolution of this issue a priority.

RECOMMENDATION #4

We recommend the Department of Administration:

A. *Work with the Montana Health Center's contractor to improve the communication and dissemination of patient medical records between the Montana Health Centers and private health care providers, and*

B. *Educate state employees and dependents on how to share patient medical records between the Montana Health Centers and private health care providers.*

Chapter IV – Weaknesses of the Montana Health Centers Contract

Introduction

The last objective of this audit was to evaluate the Department of Administration's (DOA) process for monitoring the Montana Health Center (MHC) contract to determine how centers' usage and costs are validated. The initial term of the contract between DOA's Health Care and Benefits Division (HCBD) and the contractor that operates the MHCs was for 3 1/2 years: June 1, 2012, to December 31, 2015. The contract stated that an MHC would be opened in Helena, with the option to add more centers throughout the state at the state's request. The MHCs provide primary care, health risk assessments (HRA), wellness coaching, immunizations, prescriptions, and other acute care. Audit work included reviewing the original Request for Proposal (RFP), the contractor's response to the RFP, the original contract and all subsequent amendments, interviews with HCBD staff, MHC operations reporting from the contractor to HCBD, and the costs associated with operating the centers.

Audit work found ongoing issues since the MHCs opened with regard to HCBD's management of the contract. The HCBD management team has completely turned over since the first MHC was opened in August 2012. Interviews with HCBD staff found they recognize many MHC challenges and have taken steps to make improvements, however, management challenges are still ongoing. HCBD needs to continue to make decisions regarding the future direction of the MHCs, which could potentially include creating a new RFP. This chapter discusses conclusions and recommendations made regarding HCBD's management of the MHC contract.

Core Services Outlined in Contract Not Available at Montana Health Centers

Audit work identified issues with core services that are not being provided as required by the contract. The contract between HCBD and the contractor stipulates the contractor "shall provide" several services at the MHCs, including well baby exams and workers' compensation. Audit work found these services are not currently being offered.

Well Baby Exams

Well baby exams involve measurements, vaccines, and evaluation of a baby's development. These visits generally continue weeks and months into the first year. The original contract and subsequent expansion amendments stated this service "shall" be provided at each of the MHCs. However, during implementation of the Helena MHC, HCBD decided not to offer this service. According to contractor and HCBD

staff, it would have required additional staff, equipment, and immunization costs, and it would have added additional liability costs associated with seeing children under two years old. The service was not deemed to be cost beneficial. However, the contract was never amended to indicate that this service was either not to be provided or provided optionally at the state's discretion.

Workers' Compensation and Occupational Health Services

Workers' compensation case management is also listed in the contract as a required service of the MHCs, but is no longer offered. According to the RFP, one of the goals of the MHCs was that the contractor would "reduce workers' compensation costs." The contract states the contractor shall "facilitate required medical care and the return to work process in support of the[…] Workers' Comp Case Management process managed by the state and its vendors." Both of these services were discontinued in 2015 because MHC staff received limited training to handle workers' compensation cases, and the contractor had no mechanism for billing or generating a required claim. Additionally, development of occupational health services was included as a goal of the MHCs in the RFP, but the services were discontinued because HCBD staff determined the centers were providing occupational health services to non-State Plan members, which is not allowable under statutory provisions. HCBD should either require the contractor to provide the services stipulated in the contract, or amend the contract to exclude these services.

RECOMMENDATION #5

We recommend the Department of Administration:

A. *Require the Montana Health Centers' contractor to provide all services stipulated in the contract, or*

B. *Amend the contract to eliminate stipulated services that are not performed at the centers.*

Contract Was Awarded Using Poorly Administered Request for Proposal Process

DOA issued an RFP for the Montana Health Centers on February 9, 2012, and in May 2012 an on-site health clinic operator (contractor) from Tennessee was chosen as the vendor to operate the MHCs. Both parties signed the final contract in June 2012. The first MHC was supposed to open in Helena in December 2012; however, the RFP was amended to require the opening to take place in August 2012. There was

no documentation explaining why HCBD amended the RFP to accelerate the initial MHC opening date, and HCBD staff involved with this decision are no longer with the division. We identified a number of weaknesses with HCBD's ability to effectively manage the MHC contract, including subsequent amendments made to the contracts. Much of this can be traced back to what appears to be a number of unrealistic and unclear stipulations in the original RFP, which then became part of the MHC contract. The following sections discuss these issues and how they have impacted HCBD's ability to manage the MHC contract and services.

Goals of the Montana Health Centers Are Unclear and Not Measurable

As previously discussed, HCBD staff use "primary" goals found in the original RFP for guidance on how to operate the centers. These goals include the following:

- Increase access to primary care services.
- Improve health outcomes for members.
- Improve treatment and compliance for patients with chronic health conditions.
- Provide access to health coaching and care management.
- Reduce costs for the state health plan and plan members.
- Provide health screening services.
- Reduce reliance on emergency room and urgent care.
- Improve employee productivity and reduce absenteeism.
- Develop occupational health capacity and reduce workers' compensation costs.

Audit work found many of these contract goals were either not measurable or unclear. For example, the stated goal to "reduce costs for the state health plan and plan members" does not indicate against which baseline this reduction should occur, nor does it outline a time frame for these cost reductions. An independent observer might conclude that costs should decrease immediately and relative to current-year costs. However, the on-site primary care clinic model may increase costs in the short-term, as more employees seek treatment due to incentivized expanded access; most cost savings are expected over a longer-term, as employees who might otherwise develop expensive chronic conditions instead remain relatively healthy. It is unlikely the MHCs would reduce costs relative to 2012 levels, but the goal gives no indication on which baseline costs would be reduced. Some of the other goals are similarly vague. For example, "improve employee productivity" is imprecise and difficult to quantify in any meaningful way, and some other states with on-site state employee health clinics reported that, though they hoped for increased productivity as an outcome, they

avoided making it an objective due to how difficult it is to measure and causally link to the health clinic.

Beyond this lack of specificity, the goals contain further evidence of minimal planning. In interviews, HCBD staff asserted they did not believe that reducing employee absenteeism was an appropriate goal for the MHCs, and interviews with health benefits administrators from other states agreed, largely because any change in sick leave usage is difficult to attribute to the operation of a clinic. This objective is also at odds with the goal of improving employee access to health care; by increasing access, it is reasonable to expect more sick leave is taken as employees who have not received health care in the past make appointments and are potentially referred to specialists after the discovery of undiagnosed conditions.

The RFP's goals also included developing occupational health capacity. Division administration later interpreted §2-18-812, MCA, as prohibiting the use of a portion of health plan reserve dollars on occupational health benefits, since these benefits were granted to nonmembers of the State Plan. HCBD follows additional guidelines that dictate that health plan funds should not be spent on nonmembers of the State Plan. The MHCs no longer offer occupational health services, but the initial inclusion of this service is evidence that the goals of the MHCs were not properly considered, defined, and measurable before the RFP was issued and the MHCs were implemented. However, although many of the MHC goals are not measurable, HCBD did create performance guarantees in the initial MHC contract and subsequent one-year extensions to help ensure these goals are being met.

Performance Guarantees

Contractual performance guarantees are a tool for improving contractor performance and ensuring the contractor will perform all of its contractual obligations. In the original contract for the operation of the MHCs, if the contractor was unable to achieve the results specified by any given performance guarantee, it was required to refund a portion of its management fee to the state. Audit work found HCBD's design and enforcement of the performance guarantees during the original contract term could have been improved, but the division has since improved the contract's performance guarantees with annual contract renewals.

Original Performance Guarantees Were Developed by the Contractor

Performance guarantees should be carefully chosen and expressed in clear, concise, commonly used, easily understood, measurable terms. The original performance guarantees were determined through the RFP process. The RFP required bidders to

indicate what percentage of fees they were willing to put at risk in the areas of customer satisfaction, appointment availability, and estimated cost savings. The RFP also stated "offerors must propose their best approach to outcomes measurement over the course of the contract in each of these areas." The contractor's response to RFP indicated seven categories for which it was willing to establish performance guarantees as part of providing services for the MHC contract:

- Patient satisfaction survey scores,
- Utilization of MHC appointments,
- Accuracy/on-time delivery,
- Maintain within established budget,
- Percentage of all eligible employees and spouses that participate in the HRA who visit the MHCs,
- Patient improvement of reaching and improving risk index of population, and
- Increase wellness programs and show return on investment results.

These seven categories are almost verbatim the categories for assessment in the signed contract. Performance guarantees are intended to drive the goals of the contracted service. Design of performance guarantees by the contractor rather than HCBD potentially undermined their purpose; such practice takes control away from the division and allows the contractor to define what the contract terms will be. Allowing the contractor to define what was incentivized can potentially be tied to the lack of specificity in the RFP's original MHC goals.

Conclusion

The original performance guarantees in the contract for operation of the Montana Health Centers were designed by the contractor, which reduced the integrity of the guarantees.

Assessment of Performance Guarantees

A timeline and process for assessing performance guarantees were not agreed upon until October 2013, and were not documented until January 2014, 16 months after the first MHC opened. Although the initial contract was signed in 2012, it was not until early 2015 that HCBD determined four of the seven total performance guarantees were unable to be independently measured, despite finding the contractor compliant with two of these guarantees in the previous year. These four performance guarantees were subsequently waived for 2014, with the decision to modify the performance guarantees in future years. These four performance guarantees were:

- **Meeting or exceeding budget and savings expectations:** This guarantee was waived because it required the cooperation of the state's then third-party administrator (TPA), which would not release claims data to the contractor to use for comparison. In 2013, the contractor reported the MHCs (three in operation at that point) would account for $55.7 million in potential savings in avoidance costs and was found to be compliant with the performance guarantee. Both HCBD staff and wellness industry professionals state that these avoidance cost calculations are not accurate; HCBD decided to not accept the contractor's reporting on savings in 2014.
- **Percentage of all eligible employees and spouses that visit the MHCs participate in the health risk assessment:** This guarantee was waived because HCBD was unable to determine whether 80 percent of eligible employees and dependent spouses within the MHC service area who visited a center received an HRA. It is unclear whether this guarantee was supposed to apply to all MHC service areas or only the Helena MHC service area.
- **Patient improvement of reaching and improving risk index of population:** The measurement specification for this guarantee stated that "annually the State and contractor shall agree on specific measures and improvements." The first year of this contract will measure: patient engagement; obesity; diabetes; high blood pressure; high cholesterol." These measures were not updated in subsequent years and improvement benchmarks for the existing measures were not defined. Again, HCBD was unable to obtain the data necessary to analyze health outcomes.
- **Increase wellness programs and show return-on-investment (ROI) results:** The contract stated HCBD and the contractor would agree on specific measures and ROI results annually and that HCBD would again provide the necessary claims data to measure results. HCBD was unable to provide the necessary data because of the TPA's refusal to provide the data to HCBD.

In these four cases the state did not ensure the required data would be available when the contract was signed and did not define the terms of the guarantees in the contract. In addition, several of these waived performance guarantees did not indicate specific measures for calculation or provide benchmarks for compliance. Best practices indicate performance guarantees should define outputs in clear, concise, commonly used, easily understood, and measurable terms. The three performance guarantees that were not waived for 2014 were:

- 75 percent or greater of surveyed patients express "satisfied" or higher on a patient satisfaction survey.
- The average utilization rate would be 75 percent or greater annually.
- The reports provided by the contractor to the state would be accurate and on time to standards "jointly defined by Contractor and State."

HCBD staff concluded these three performance guarantees were ineffective at incentivizing the contractor to provide a high level of primary care and to make measurable positive impacts on State Plan member health outcomes.

Conclusion

Because of the limitations of both the contractor's and Health Care and Benefits Division's data, the division has not been able to independently verify the contractor's reporting on its compliance with performance guarantees.

Performance Guarantees Have Been Amended

In 2015, performance guarantees for 2016 were amended in entirety when the contract was renewed for another year. The new guarantees directly addressed population health management outcomes and specific changes to the contractor's data capture, online scheduling, and reporting systems. These performance guarantees were more specific and established more measurable goals than those in the original guarantees. However, these amended performance guarantees did not precisely define many of the metrics used and did not provide explicit guidance on how each metric should be calculated. As a result, HCBD relied on the contractor to define and outline how the performance guarantees would be measured. Although the definitions and calculation procedures outlined by the contractor appeared to conform to the contractual language, relying on the contractor to define the terms of the guarantees after the amendment has been signed undermines the guarantees. The contractor has never been found noncompliant with performance guarantees, possibly due to the contractor developing the performance guarantees and HCBD not tying the guarantees to clearly defined and measurable MHC goals. Current HCBD management is trying to address some of the weaknesses we found with the guarantees. Near the end of our audit work, HCBD changed performance guarantees into performance bonuses. The intent is to now reward the contractor for good performance rather than punishing it for poor performance. The performance bonuses are better designed than their predecessors, with the guarantees being clearer and more measurable. In addition, in December 2016 HCBD contracted with an auditing firm to determine what data is available to establish baselines for performance guarantees, and then analyze whether these guarantees are achieved. The firm will also review reports provided to HCBD by the contractor and provide a written report that compares performance and the guarantees.

Recommendation #6

We recommend the Department of Administration tie performance guarantees or any other contract incentives to the goals of the Montana Health Centers using clear, precise, and easily understood language with clearly defined, measurable outcomes.

Montana Health Centers' Electronic Medical Records Data Is Insufficient

Accurate and comprehensive data allows contract activities to be actively monitored and to determine if contract goals are being met. However, audit work found HCBD lacks data to effectively monitor the MHC contract and determine whether the contractor is meeting contract requirements. Since the inception of the first MHC in August 2012, HCBD staff has rarely had enough data to undertake thorough analysis of the performance and ROI of the centers. As a result, HCBD has had to rely upon the contractor's own reporting data, which has been inconsistent and unreliable. HCBD has attempted to improve the contractor's reporting, especially through the implementation of performance guarantees, but the condition of the data is not yet sufficient to conduct rigorous analysis of MHC-related health improvements or cost effectiveness. Through June 2015, HCBD outsourced the storage and analysis of health care claims data from the TPA and EMR data from the contractor to a nonprofit entity that specializes in health care data. At the end of 2015, the state terminated its agreement with this entity because it could not meet HCBD standards. Requested data would take as long as six weeks to be delivered and was unreliable when obtained, according to HCBD staff.

The lack of data also contradicts the original RFP, which stated two goals of the MHCs are to "improve health outcomes for members," and to "improve treatment and compliance for patients with chronic health conditions." Without data, such as a means to positively identify the patient, it is harder to measure and accomplish these goals, especially regarding the treatment of patients with chronic conditions. Without a detailed record showing why a patient visited an MHC, it is difficult for providers to determine and implement a long-term health improvement plan for the patient, which further inhibits the ability to know if patient health is improving. In addition, the contractor's RFP stated that its "proven web-based analytic technology transforms claims data" into management information that can help clients understand, predict, and lower benefit costs. The data limitations for the first four years of MHC operations makes it unlikely that this will happen.

After HCBD terminated its agreement with the entity that stored patient data, it initiated the implementation of its own data warehouse, housed at DOA's State Information Technology Services Division (SITSD). The data warehouse will be comprised of data from all of the State Plan's vendors (i.e. the MHC contractor, the health care TPA, the dental TPA, and the pharmaceutical TPA), which will allow HCBD staff to have direct access to all data and run its own reports regarding patient health outcomes. While this new system has been in the process of design and implementation, HCBD has relied upon a contracted risking software, its TPA, and its contracted actuary to assist with data management. After multiple delays regarding the implementation date of the data warehouse, it was scheduled to be fully operational in early 2017; however, it is still in the testing phase. Until the data warehouse is fully functioning, HCBD's ability to conduct cost-benefit analysis and to make well-informed decisions regarding health center operations will be constrained.

Lack of Data Impacting How Health Care and Benefits Division Can Improve Montana Health Center Effectiveness

New HCBD management has attempted to improve MHC effectiveness by updating performance guarantees, questioning the contractor's reporting, and making cost-saving changes to MHC services. However, lack of sufficient data has adversely affected HCBD's ability to manage the MHC contract. HCBD has been unable to independently verify much of the contractor's reporting. For example, the use of standardized diagnosis or medical procedure codes within the electronic medical records (EMR) was inconsistent until 2016. This is because from 2012 through 2015, MHC providers did not insert CPT codes into EMRs, making it difficult for HCBD staff to track employee health. The inconsistency of diagnostic and medical procedure codes within the contractor's EMRs has affected the contractor's ability to properly plan for long-term patient care and HCBD's ability to perform health outcome and cost analysis. The EMR is also necessary to perform cost comparison to non-MHC providers, and to ensure appropriate coordination of care for patients, an area that needs improvement according to our surveys of both state employees and hospitals.

The contractor's response to the RFP indicated that it would create and use reports that would identify patients whose conditions require more care than they are currently receiving. Despite performance guarantees that indicate these reports must be used, HCBD staff report the contractor has not instituted their regular use. During the course of this contract term, ARM 2.5.303 stated "agencies are responsible for receiving …services procured on their behalf by the [Procurement] division. 'Receiving' means inspecting…the service and checking it against the contract to ensure that it is acceptable, complete, and in compliance with the terms of the contract." This ARM was updated in July 2016; however, the rule above was in place for much of the initial

contract period between the contractor and HCBD. Without access to the appropriate data, HCBD cannot inspect contracted services. Staff in other states with similar state employee health clinics report they analyze metrics related to their clinic's costs and impacts. For example, staff in Tennessee report they evaluate whether employees who use the clinic use emergency room services less frequently than other employees do. Reducing plan member reliance on emergency room and urgent care is a goal of the MHCs, but HCBD has not been able to perform a similar evaluation to determine any impacts on emergency room usage. Access to reliable data allows management to undertake this sort of analysis and make well-informed decisions regarding clinic operations.

RECOMMENDATION #7

We recommend the Department of Administration finalize the development of the data warehouse and collect accurate and comprehensive data to verify that contract goals are being met.

Contract Modifications Should Be Documented

During audit work we identified instances of modifications to the contract between HCBD and the contractor that were not in compliance with contract stipulations or were lacking proper documentation. The following section provides examples of such modifications to the contract.

Remote Health Risk Assessments

One of the functions of the MHCs is to provide annual health risk assessments (HRA), which is a blood draw and lab tests, to employees and their dependents covered under the State Plan. The RFP and subsequent contract included a provision for employees living outside of the range of an MHC to receive HRAs. This is done through contractor-employed phlebotomists that travel to locations around the state with no local MHC. The subsequent contract stipulated that costs for remote HRAs would be $55 per HRA, plus up to $63,825 per year to cover costs for 2.84 full-time employees at a rate of $15 per hour.

The contract contained a provision that did not allow changes to the contractor's rates for the duration of the initial three-year contract term. However, just over one year later in July 2013, HCBD and the contractor signed an amendment to the original three-year contract, which allowed for mileage reimbursement at a rate of $0.55 per-mile for all travel to and from remote HRA locations. More substantial rate changes were agreed

upon verbally, allowing the contractor to invoice increased remote HRA staffing costs, both for more hours worked by employees and for higher rates of pay, including the addition of a remote HRA manager. The rationale for these changes was that the demand for remote HRAs was higher than described in the RFP, involving more visits than anticipated. However, the total number of remote HRAs performed each year was, in fact, lower than outlined in the response to RFP. This resulted in the contractor being paid more than it should have been. Allowable and paid costs for remote HRA services are displayed in Table 10. This includes the amounts the contractor was paid in excess of what the contract allowed.

Table 10

Allowable and Paid Expenses for Remote Health Risk Assessment Services

Year	Allowable Expenses in Original Contract	Allowable Expenses in Amendment*	Expense Paid	Excess Amount Paid in Original Contract	Excess Amount Paid in Amendment
2013	$326,835	$335,746	$ 374,927	$ 48,092	$ 39,181
2014	270,625	291,714	329,908	59,283	38,194
2015	231,245	247,088	325,850	94,605	78,762
Total	**$828,705**	**$874,548**	**$1,030,685**	**$201,980**	**$156,137**

Source: Complied by the Legislative Audit Division from HCBD expense data, HRA records and contracts.

*Includes $0.55 per-mile travel expense as part of a contract amendment.

For remote HRA services, HCBD paid the contractor $156,137 more than allowed in the contract amendment, which amounts to $201,980 more than allowed by the original contract. All expenses in excess of the contractual rate were reimbursements of staffing, mileage, and supply costs. Interviews with industry professionals indicate the original contracted rates were unrealistically low even though this is what the contractor agreed to when it signed the contract.

Costs of Remote Health Risk Assessments in Noncompliance of Contract and Amendments

With the exception of mileage reimbursement, HCBD declined to formalize the changes to allowable billing costs via contract amendment. Audit work determined the contract stipulated that any modification to contract terms required formal "mutual written agreement" upon both parties. At the time the changes were agreed to in 2013, HCBD reasoned that no amendment was necessary. HCBD was unable to provide documentation regarding the specific terms of the agreement to allow increased charges for remote HRAs. HCBD's decision to allow increased expenses for HRAs after the

contract was awarded was in violation of the contract terms. Allowing such changes undermines the competitive bidding process.

In July 2016, HCBD issued an invoice to the contractor seeking reimbursement of $141,871 paid for remote HRA staffing in excess of the amended contract terms, which was then disputed by the contractor. A lack of documentation coupled with staff turnover at HCBD led to confusion over the verbally agreed-to terms. Interviews with both HCBD and contractor staff revealed the dispute over this invoice for reimbursement has led to a deterioration in collaborative relations between the contractor and HCBD.

RECOMMENDATION #8

We recommend the Department of Administration document any contract modifications to the Montana Health Centers through a mutual, written agreement between the department and the contractor.

The Health Care and Benefits Division Does Not Have a Clear Vision for the Montana Health Centers

Throughout this report we have shown the MHCs are popular and are being used by state employees and their dependents. When the MHCs were implemented, two goals in the RFP included improving access to primary care services and improving health outcomes for members of the State Plan. Although data cannot confirm these have occurred, the employee survey found that respondents are using the MHCs in high numbers, are largely satisfied with the care they receive, and some have found health risks that could amount to major health problems in the future if not treated effectively. These cases could result in long-term costs savings for the state if treated presently. In addition, the MHCs have become a primary care provider for many state employees and their dependents, and have given an avenue for some patients to visit a health care provider that have not done so regularly in the past.

Ineffective Montana Health Center Operations Due to Poor Contract Management

A lack of effective contract management on the part of HCBD has resulted in several weaknesses related to MHC operations. Overall, audit work found HCBD and the contractor have not effectively tracked the health outcomes of patients and cannot accurately determine cost savings when comparing MHC costs to costs for similar

services in the private health care sector. In addition, there are a number of other concerns we found during audit work that have been discussed throughout the report, which are summarized below.

- **MHC goals are not measurable:** We identified a number of weaknesses with HCBD's ability to effectively manage the MHC contract, including subsequent amendments made to the contracts. Much of this can be traced back to what appears to be a number of unrealistic and unclear stipulations in the original RFP, which then became part of the MHC contract. When the RFP was issued, there were 11 goals used to guide the operations of the MHCs. However, audit work found that many of these goals were not measurable or not a good indicator of MHC success. For example, one goal was to reduce absenteeism by employees but audit work found this was not occurring. Our analysis of state employee sick leave use found there was little difference between employees who used MHCs and employees that do not use them. Interviews with HCBD staff found they did not agree with the goal and have not attempted to measure it because there is not a baseline against which to compare present sick leave use to. Other goals, such as reducing reliance on emergency room and urgent care services, are hard to measure, according to HCBD officials.
- **MHC electronic medical record data is not accurate and complete:** Initial patient EMR data for the first several years of MHC operations did not allow HCBD staff the ability to track patient health or determine why patients were visiting the MHCs. This is because from 2012 through 2015, MHC providers did not use proper codes in electronic medical records, making it impossible for HCBD staff to track employee health. EMRs also lacked other key data, such as the location of the MHC where visits took place, which makes it impossible for HCBD to get a true cost-per-visit by location. HCBD staff has taken a more proactive role in trying to require better data from the contractor for analysis purposes.
- **Original performance guarantees were not measurable:** As discussed, the original performance guarantees were designed by the contractor, which potentially undermined their purpose. These performance guarantees, which were put in place to ensure the contractor was effectively operating the MHCs, did not have defined baselines against which to measure outcomes. Audit work found the contractor potentially might have not met vacancy rate requirements in performance guarantees, which would have allowed them to avoid refunding a portion of its management fee. Since 2016, HCBD has made positive changes to the guarantees, which now hold the contractor more accountable.
- **MHC expansion was not properly planned:** Audit work determined the expansion of the MHCs was not based on logical analysis and employee needs. The RFP was amended to require the eventual contractor to open the MHC in 2012 and two new centers in 2013. This expedited expansion eventually led to an MHC in Miles City that has been underutilized since its implementation, while there are still other cities in Montana with large employee populations that do not yet have a center. In addition, there is not a plan in place to address whether or not future MHCs would continue to be stand-alone centers or partnerships with existing local health care providers.

- **Documentation from contractor is often inaccurate or difficult to interpret:** Audit work found that reports from the contractor did not align with patient EMR data. Specifically, our work found primary visit totals from 2012 through 2015 were significantly different than totals found in appointment and vacancy reports developed by the contractor. Furthermore, interviews with HCBD found that other reporting from the contractor is difficult to analyze and understand.
- **Unfounded savings to the state:** With the lack of accurate and complete data, HCBD cannot definitively determine if the implementation of the MHCs are saving the State Plan money on health care costs, despite claims to the contrary. It should be noted those employees and dependents with reasonable access to the MHCs are likely saving money out-of-pocket because of the lack of co-pays and deductibles attributed to services given at the centers.
- **Disruption of care between the MHCs and local hospitals:** Through interviews and surveys with hospital staff located within the service areas of existing MHCs, we found there is a lack of communication between these two entities, especially when it comes to the use of the centers' patient EMRs. Ultimately, this could result in the duplication of services and a delay in care for those patients that visit both the MHCs and private providers.
- **Primary care vs. wellness care:** Currently the MHC business health care model focuses on two main areas: primary care and wellness coaching. Primary care includes services such as treatment for common illnesses, chronic and acute conditions, and other services such as comprehensive wellness physicals, while wellness services focuses on programs intended to improve and promote health and fitness (usually based on results of a blood test done as part of a patient's annual HRA). Interviews with HCBD staff found they do not know if this is the best model to operate under. For example, before the MHCs were created a contracted vendor traveled the state and conducted HRAs for employees and dependents. There is confusion whether the current model ultimately fits the needs of the state; are the MHCs meant to address services dealing more with urgent care, or for services aimed at improving the long-term health of patients?

Montana Health Centers Developed Under a Lack of Transparency and Vision

All these concerns generally tie back to the original planning and development of the MHCs. From the time the idea of the MHCs was presented to the time the first center opened was within a span of eight to nine months. The RFP was created with little input from stakeholders, including state employees, legislators, the Montana University System, and local health care providers. It does not appear any of these stakeholders had input on MHC development, vision, or goals, or how to define success of MHC operations. This lack of clear vision is responsible for many of the issues identified during audit work. Other states with similar employee health clinics have approached

the implementation of their clinics more cautiously and with specifically defined expectations.

Decisions Need to Be Made on Montana Health Centers' Future

The contract between HCBD and the contractor is currently in its fifth year. The initial contract went from June 1, 2012, through December 31, 2015, with one-year extensions signed in early 2016 and 2017. Under §18-4-313(1), MCA, a contract for services may not be made for a period of more than seven years. However, under §18-4-313(2)(d), MCA, HCBD is given an exception to this law and is allowed to administer state employee group benefit plans for a period not exceed ten years under §2-18-811(2), MCA. As such, HCBD will have to issue a new RFP to start a new contract by June 2022. With all the MHC concerns outlined in this report, decisions should be made regarding if MHCs are health care tools the state of Montana wants to continue providing. Such decisions would involve assessing whether to continue to operate the MHCs with a focus on both primary care and wellness services, or if the MHCs should be used primarily for only one of these services. One of the main concerns from legislators in 2012 when the MHC idea was presented to the public was the lack of transparency in how the MHCs would benefit State Plan members, and legislators' lack of involvement in the process, particularly when they are responsible for appropriating funds to pay for the State Pan. If HCBD and the appropriate stakeholders (legislators, local health care providers, the Montana University System, and state employees) believe this is a health care benefit that should continue, it may be a time for HCBD and its stakeholders to begin developing a vision for the MHCs that outlines how they fit into HCBD's long-term health care strategy. To support this vision, HCBD should develop measurable goals, define how the centers will benefit the state of Montana and its employees, clearly define how these goals will be measured, and ensure the data needed to do so will be available. HCBD would also need a formal and documented process that ensures proactive contract management occurs and ensure the successful contractor is meeting the terms of the contract.

RECOMMENDATION #9

We recommend the Department of Administration work with stakeholders to determine if the Montana Health Centers should continue to be a health care option for state employees, and either:

A. *End Montana Health Center services at the end of the current contract extension period, or*

B. *Develop and submit a new Request for Proposal based on a clearly defined vision and goals.*

Department of Administration

Department Response

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June 13, 2017

RECEIVED
June 13, 2017
LEGISLATIVE AUDIT DIV.

Angus Maciver, Legislative Auditor
Legislative Audit Division
PO Box 201705
Helena, MT 59620

Dear Mr. Maciver,

Thank you for the opportunity to respond to the audit of State of Montana Health Centers. We appreciate the professionalism of the LAD staff throughout this comprehensive audit.

Our comments to the audit recommendations are as follows:

Recommendation #1 – We recommend the Department of Administration:

A. *Require use of standardized definitions for an office visit, ancillary visit, and an encounter with the Montana Health Centers, and*
B. *Require the contractor to provide accurate Montana Health Center appointment and vacancy reporting based on actual appointment times*

Department Response: Concur

The department concurs with this recommendation. The department began working with the vendor and our Third Party Administrator (TPA) on July 5, 2016 to standardize the definitions for office visit, ancillary visit and encounter and subsequent reporting. This will be completed by December 31, 2017.

Recommendation #2 – We recommend the Department of Administration develop a process to independently and accurately compare and report health service costs and benefits of the Montana Health Centers to similar services, including those:

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A. Provided by local health care providers under a cost-per-service model, and
B. Provided under a value-based design model

Department Response: Partially Concur

The department recognizes the desire to accurately compare and report health service costs and benefits. The challenge is completing an appropriate cost comparison with the marketplace in general, as other provider or vendor contracts protect privacy of fees and other terms.

The department currently compares costs of the Montana Health Centers to those of a fee-for-service model. The department is able to complete this analysis, as it participates in fee-for-service arrangements under the TPA contract and is able to access this data for comparison purposes. Additionally, the department has been working with the vendor and the TPA to develop population management reporting to compare benefits under both models. Provided future Montana Health Center models follow a fee-for-service structure, the department agrees to report as recommended.

A value-based design clinic model may be utilized with future Montana Health Centers, which is focused on obtaining maximum health outcomes for the members. The provider compensation is based on achieving specific standards of quality, health outcomes, integrated and coordinated care, and other measures. As such, the department would not have comparable pricing available for the marketplace, as the department does not hold similar contracts with other providers, and related contracting/pricing is confidential. The vendor receives base compensation, and then additional payments should targets be achieved. Should the department adopt this model, specific targets and metrics will be identified, measured and reported. While this reporting will not compare cost and benefits to similar services in the marketplace, it will compare actual performance with specific targets.

Recommendation #3 – We recommend that the Department of Administration:

A. Clearly define, in a growth strategy, criteria for any potential future expansion of the Montana Health Centers that addresses state employee populations, and partnering with local health care providers where expansion is feasible, and
B. Determine if the Miles City Montana Health Center should be closed or partnered with a local health care provider

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Department Response: Concur

The department concurs with this recommendation. The department completed a strategic planning session May 24, 2017 and is currently finalizing the Montana Health Center strategy.

Recommendation #4 – We recommend the Department of Administration:

A. *Work with the Montana Health Center's contractor to improve communication and dissemination of patient medical records between the Montana Health Centers and private health, and*
B. *Educate state employees and dependents on how to share patient medical records between the Montana Health Centers and private health care providers*

Department Response: Concur

The department concurs with this recommendation. The department initiated several employee engagement tools, including Health Care Blue Book, Webinars, Health Center programs and NaviGate GPS. In line with current employee engagement efforts, the department agrees to include information for employees regarding the patient medical record and its exchange with private providers. These initiatives fit well with our overall goal of continuing education to ensure Montana remains in the forefront of providing education on health care topics.

Recommendation #5 – We recommend the Department of Administration:

A. *Require the Montana Health Center's contractor to provide all services in the contract, or*
B. *Amend the contract to eliminate stipulated services that are not performed at the centers*

Department Response: Concur

The department concurs with this recommendation and drafted an amendment to remove Well Baby, Occupational Health and Worker's Compensation services from the contract. The department completed this change in draft Amendment 11 and will be presented to participating employer groups and the vendor for approval.

Recommendation #6 – We recommend the Department of Administration tie performance guarantees or any other contract incentives using clear, precise, and easily understood language with clearly defined, measurable outcomes

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Department Response: Concur

The department concurs with this recommendation. In 2015, the department revised all performance guarantees for the 2016 contract year, which are defined in amendments 8 and 9. As stated, "the new performance guarantees were more specific and established more measurable goals than those in the original guarantees."

In addition, the department contracted with CTI to audit the contractor's performance against these guarantees. The 2017 performance guarantees were established in Amendment 10, with half based on measurable outcomes, designed to provide a bonus in line with a value-based design.

Recommendation #7 – We recommend the Department of Administration finalize the development of the data warehouse and collect accurate and comprehensive data to verify that contract goals are being met

Department Response: Concur

The department concurs with this recommendation and continues work towards a data warehouse solution. Future plans include exploring options for contracting with a third-party for independent verification and validation of the data. In the interim, the department is working with the TPA to finalize data warehouse and analytics services provided under the TPA contract at no additional cost. The services will be fully implemented October 1, 2017.

Recommendation #8 – We recommend the Department of Administration document any contract modifications to Montana Health Centers through a mutual, written agreement between the department and the contractor.

Department Response: Concur

The department concurs with this recommendation. In 2015, the department conducted a thorough review of the contract and completed RFP documents to identify potential areas of inconsistency between the documents and the actual performance. Subsequently, the department met with the vendor in June 2015 to review the identified items, which resulted in both adding some services and reporting to the performance or making appropriate contract changes in amendments 8 through 10. Also, the department negotiated an 18% reduction in administrative fees.

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Recommendation #9 – We recommend the Department of Administration work with stakeholders to determine if the Montana Health Centers should continue to be an option for state employees, and either:

A. *End Montana Health Center services at the end of the current contract extension period, or*
B. *Develop and submit a new Request for Proposal based on clearly defined vision and goals*

Department Response: Concur

The department concurs with this recommendation. The department completed a strategic planning session on May 24, 2017 focused on the health centers, and plans to work collaboratively with CareHere to align the contract with the goals and vision of the Montana Health Centers.

Feedback from surveys indicates high levels of positive feedback from employees that utilize the Montana Health Centers, and improved reporting indicates positive changes to health outcomes. There is no plan to end the existing Health Center services.

The department will remain in the existing contract with CareHere and will work to implement the recommended action items.

The future of healthcare will rely on developing solutions for cost containment, improved health outcomes, and plan management. Montana is an innovator, being the first state to have all hospitals on reference based pricing methodology for state health plan reimbursements, and the first to offer an expansive network of employee clinics. Montana will continue to be a leader in finding innovative, effective and collaborative ways to reduce healthcare costs.

Sincerely,

John Lewis, Director

cc: Marilyn Bartlett, Administrator